Mental Health Services Act Innovation Proposal
Resiliency Empowerment Support Team (REST) at Everhart Village

County Name: Butte
Date submitted: 3/8/2022
Total amount requested: $3,510,520
Duration of project: July 01, 2022 – June 30, 2027
☒ Local Mental Health Board Approval: January 19, 2022
☒ Completed 30-day public comment period: December 20, 2021- January 19, 2022

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☒ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☒ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☒ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☒ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Barriers to Engagement in Behavioral Health Services

Social and physical barriers at both an individual and provider level significantly impede Butte County Behavioral Health's ability to engage and serve vulnerable community members eligible for services. In Butte County, a combination of local disasters, homelessness, high crisis and inpatient utilization, and significant prevalence of co-occurring disorders has reached a crisis point that requires innovative action to develop future best practices to mitigate barriers to treatment.

Individual-Level Barriers

The barriers that potential behavioral health clients face are multi-dimensional and can include, but are not limited to, and may be a variation of, the following:

Stigma

- Negative self-stigma and embarrassment about having a mental illness
- Self-reliance and the fact that seeking treatment may look like a sign of weakness
- Fear of life disruption (involuntary treatment, losing rights, property, legal consequences)

Mental health symptoms

- Problems recognizing symptoms or lack of insight into a mental health condition (anosognosia)
- Feelings of hopelessness may lead to beliefs that "nothing can help"
- Previous experiences in trying to get help with a negative outcome
- Extensive amount of time without treatment exacerbates the seriousness of symptoms

Addiction

- Fear of legal repercussion/consequences for illegal drug use
- Impaired ability to keep appointments and commitment to treatment
- Lack of motivation to quit may alienate them from mental health treatment
- Fear of withdrawal combined with lack of detox services in rural areas

Practical

- Individual lacks reliable transportation or driver's license
- Rural characteristics (lack of robust public transit system, lack of service providers, conditions of sidewalks make use of mobility devices difficult)
- Unreliable access to cell phone, internet, and email
- Extreme weather conditions
- Lack of affordable housing or shelters, location of shelters
- Lack of available health care providers that accept Medi-Cal
- Lack of informal supports, or minimal family involvement to assist with support

Complex or Chronic Untreated Health Issues

- Medical and mental health conditions impairing accessibility of services
- Lack of continuity of care between and within health providers
- Increased co-morbidities leading to early death[1]
- Lack of education regarding the importance of integrated health
- History of negative experiences related to stigma in treating the behavioral health population

Provider Level Barriers

County Characteristics

Butte County is a rural, low-income county facing many socio-economic challenges. Rural counties often face substance use and mental health issues, have a high amount of aging and vulnerable populations, lack access to health care, and have poor education quality. Butte County has one of the highest ACEs (Adverse Childhood Experiences) scores in the entire State, signifying higher rates of childhood trauma with a direct connection to poor physical and mental health outcomes. Rural counties also battle higher rates of stigma associated with seeking mental health and substance use disorder treatment.

Approximately 18.5 percent of persons in the County meet or fall below the federal poverty line, compared to 12.8 percent in California and 11.8 percent nationally (US Census Bureau 2019)[2]. The lower socio-economic status of many Butte County residents is generational; many families experience social and economic burdens that appear at higher rates in low-income households such as unemployment, financial instability, food insecurity, lack of access to transportation; childhood and older adult abuse and neglect; mental health disorders, and substance use and dependence disorders. Butte County exceeds the statewide average of Medi-Cal beneficiaries as well as Medi-Cal penetration rates; approximately 28 percent of residents are enrolled in Medi-Cal, compared to roughly 18 percent of Californians (DHCS 2018; US Census 2017).

In two short years, Butte County has experienced the devastation of several communities by wildfires. Thousands have been displaced and endured the trauma of loss of life and property to wildfires. In November 2018, our community witnessed the most destructive wildfire in California's history. The Camp Fire decimated most of the town of Paradise (population 26,218) and its surrounding mountain communities of Magalia and Concow, killing 85 and destroying approximately 13,000 homes. Adding to the Camp Fire related trauma and displacement, on September 9, 2020, the North Complex Fire leveled the County town of Berry Creek (population approximately 1,300) with only a few homes left standing. The North Complex Fire was the sixth-largest fire recorded in California's modern history, prior to the combustion of the Dixie Fire (see below), and the deadliest fire in the 2020 California wildfire season with 15 deaths.

The massive loss of lives, homes, and sense of community combined with the direct trauma of so many literally trapped in the flames touches not just those individuals, but their loved ones and ultimately the whole community resulting in an immeasurable rate of vicarious posttraumatic stress disorder (PTSD). Each time the wind blows like it did the day of the Camp Fire, a plume of smoke is seen, or another loss, no matter how commonplace, symptoms of PTSD are triggered. Many have suffered multiple evacuations or have lost all their food in yet another safety power shut-off. PTSD recurrence and remissions seem to ebb with these events, and each year more people ultimately choose to leave the area when it seems the only way to reduce their symptoms. For example, in August of 2021 the Dixie Fire began in Butte County, near the same area that the Camp Fire began. Many community members held a collective breath as the fire, which is now considered the second largest fire ever recorded in California, moved out of the Butte County area.

Homelessness

On September 25, 2018, the Butte County Board of Supervisors adopted a resolution declaring a shelter crisis in Butte County. The resolution also allowed the Board, on a case-by-case basis, to authorize the use of vacant or underutilized County property for purposes of emergency sheltering. In addition, the resolution allowed the use of alternate health, housing, and safety standards for facilities in lieu of State and local statutes, regulations, or ordinances. Subsequent to the adoption of the resolution, the shelter crisis situation in Butte County worsened as the Camp Fire and the North Complex Fire destroyed thousands of homes. With 18.9 percent of the County's housing stock destroyed in the Camp Fire, displaced residents have found it difficult and at times impossible to obtain and retain suitable housing at manageable costs. Additionally, the lack of availability of appropriate, affordable housing has been exacerbated due to the current global pandemic. On August 10, 2021, the Board adopted a resolution extending the shelter crisis declaration which will now expire on June 30, 2024.

The Homeless Point in Time (PIT) Survey is federally-mandated by the U.S. Department of Housing and Urban Development (HUD) to survey the sheltered and unsheltered homeless population in cities and counties throughout the nation. The bi-annual *2019 Homeless Point in Time Census* showed 2,304 homeless persons (891 unsheltered, 420 sheltered, and 993 sheltered with FEMA support) within Butte County, which was 16% higher than 2011. Of the 2,304 identified:

- 1,413 sheltered homeless, living in shelters or transitional housing for the homeless.
- 891 unsheltered homeless, those who reside in places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street.
    - 71% responded that they lived in Butte County when they became homeless
    - 42% responded that they were homeless for the first time
    - 23% responded that they were homeless for the first time due to the Camp Fire

The actual number of homeless individuals in Butte County is estimated to be higher than the PIT survey results due to ongoing challenges in locating homeless individuals to survey; implications from wildfires and more recently, the global pandemic.

In Butte County, the high rate of homelessness directly correlates with a subset of the population who are eligible for behavioral health services, but are reluctant to engage in treatment due to barriers cited on page 4. The 2019 PIT reported that 22% of unsheltered adults self-disclosed a serious mental illness and 12% disclosed a substance use disorder. According to HUD in 2015, on average, 45% of homeless in America have mental illness, 25% are seriously persistently mentally ill. Mental illness is a major contributor to homelessness and is the third leading cause of homelessness. Untreated mentally ill individuals find it difficult to live on their own or have an inability to maintain their housing. Homeless individuals with serious mental illness and/or substance use disorders prioritize basic needs such as food and shelter over accessing and maintaining mental health services.

Substance Use Disorder (SUD) Treatment

The current delivery structure for SUD services is not a good fit for the high needs/high utilizer clients our innovation program targets. The existing SUD system and state regulations of SUD services create barriers to participation for some client groups, particularly those lacking stable housing or transportation and suffering from significant co-occurring mental health disorders. For example, state regulations require that a client attend a minimum of two group counseling services every 30 calendar days to remain open in SUD services. It is common for participants to miss the required number of groups and as a result be discharged; subsequently the beneficiary must start from square one with a new request for services. Community members without a consistent residence are at a higher likelihood of missing the required number of groups and have a higher likelihood of encountering barriers to participation or delays to reengaging. More flexible, field-based SUD treatment interventions have been, in our agency experience, difficult to fund, coordinate, and deliver. From a broader systems perspective of barriers, mental health and SUD treatment being "siloed" creates barriers. One unintended consequence of this siloed system is that it duplicates the client burden of scheduling and attending services. Obviously, this additional burden for clients with co-occurring disorders is at best a disincentive and at worst an insurmountable barrier to treatment participation.

Community Reported Barriers

In the 2019, MHSA Community Input stated that the community felt that the most significant barriers to accessing treatment include:

- lack of knowledge about programs
- lack of transportation to appointments
- concerns about cost
- unsupportive family/family conflict
- difficulty in communicating with clients who do not have a phone

The 2020 MHSA Community Input survey results showed that 67.2% of the survey respondents felt that the homeless community has the highest need for mental health services and supports. Barriers to treatment prove to be the biggest obstacle in engaging homeless individuals who would benefit from behavioral health services.

The Current System

The current system in Butte County for treating the Severely and Persistently Mentally Ill, both homeless and non-homeless, consists of the following programs:

Crisis Triage Connect

The Connect Team facilitates consumer movement through the crisis continuum; including coordinating hospitalization placement as needed, discharge planning, monitoring, and follow-up case management. The Connect Team provides support both for hospitalized clients and those who are high utilizers of crisis services (defined as 3 or more crisis evaluations in a 30-day period).

Mobile Crisis Team

The Mobile Crisis Team collaborates with law enforcement to provide crisis-related outreach and engagement, as well as respond to 911 requests regarding possible psychiatric or emotional crisis in the community. The Mobile Crisis Team provides consultation, crisis assessment, and engagement of the individual in need.

Support, Engagement, Advocacy, Recovery, Community, & Housing (SEARCH)

SEARCH is a full service partnership program, funded through the Mental Health Services Act, which provides intensive services to adults who are homeless or at-risk of homelessness due to a severe and persistent mental illness. SEARCH provides intensive outreach services for purpose of providing treatment to currently enrolled clients. The REST Program, by comparison, will be providing intensive outreach services for the purpose of engaging potential clients in treatment.

Youth Intensive Programs

Youth Intensive Program is a full service partnership program for youth and their families. It is integrated across agencies and programs to provide coordinated care to consumers through an easily accessible process. This process enables wrap-around teams to address the unique needs of individual families and youth.

Substance Use Disorders Services

Substance Use Disorders Services provides assessment, diagnosis, treatment and recovery services to individuals facing substance use challenges, substance use challenges related to alcohol use, narcotic or prescription use, marijuana, and/or stimulant use. Referrals to community resources are also provided. There are specialized programs for Medication Assisted Treatment, women who are pregnant or parenting children, and felony offenders who have substance disorders.

The current system is working well for clients that are motivated and high functioning enough to engage in treatment. The most recent data (FY 2019-20), for The Chico SEARCH Program shows that 81.3% of the consumers avoided a psychiatric hospitalization, 65.6% of them enrolled in a vocational program during the fiscal year, and 50 % acquired housing. The current system is also effective at helping clients when they are in crisis. The most recent Crisis Services data (FY 2019-20), shows that there was a 22.3% decrease in total psychiatric hospitalizations compared to the prior fiscal year which resulted in a 25.7% decrease in psychiatric hospital placements of consumers.

The current system is not working well for individuals that are not able to engage in ongoing outpatient mental health services. It is estimated that Butte County is currently providing ongoing, outpatient treatment to 19 percent of the severely mentally ill homeless population in the County. The bi-annual *2019 Homeless Point in Time Census* showed 2,304 homeless persons within Butte County. According to HUD in 2015, on average, 25%

of the homeless in America are seriously persistently mentally ill. The number of homeless people in Butte County with a severe mental illness could therefore be assumed to be 576, i.e. 25 percent of the 2304 people that are of homeless (2,304 x .25 = 576). In Butte County Full Service Partnership Programs, 111 (23.1 percent), of the 481 participants self-report as homeless. Therefore, Butte County is currently treating 19 percent (111 of 576), of the severely mentally ill homeless population in the County. A simplifying assumption is that all of those with serious persistent mental illness (SPMI) in ongoing outpatient treatment are receive that treatment in Full Service Partnership programs. Note that the Severely and Persistently Mentally Ill, that are not homeless, are also the target population for the REST Program.[1]

Pilot Programs

In the last few years, Butte County has launched two initiatives to test the feasibility of reaching and treating the severely and persistently mentally ill, who are currently not engaged in outpatient mental health services:

Expanding the scope of the Crisis Triage Connect

In 2020, Crisis Triage Connect began helping high utilizers of crisis services, in addition to its core mission of helping hospitalized mental health clients. The Connect Team now provides intensive outreach services for about 25 high utilizing crisis clients every year.

Intensive Outreach Pilot

Butte County ran a small Intensive Outreach Pilot program from February - May 2021. The Intensive Outreach Pilot utilized two case managers and their existing supervisors from the SEARCH program. The Intensive Outreach Pilot tested elements in the proposed REST program, including:

- Targeting the difficult to engage, severely and persistently mentally ill;
- Targeting the homeless;
- Providing intensive outreach services using an Assertive Community Treatment (ACT) model.

Out of 16 clients referred to the pilot, 6 were successfully engaged and linked to services; 7 could not be engaged by the time the pilot finished; 3 could not be helped due to incarceration, active criminal charges, and/or no longer residing in Butte County. Therefore, the Intensive Outreach Pilot Team was able to engage about 46 percent of target clients in relevant services.

Lessons learned from these two pilot programs

1. *It is possible to engage this high needs, treatment resistant population.*
   As one supervisor in the Intensive Outreach Pilot explained, "It is not one problem. It is a million tiny problems. But, when you really focus in, there are solutions." A preliminary estimate is that 46% of the currently unengaged Severely and Persistently Mentally Ill client population can be successfully engaged in services.
2. *Butte County has the capability to perform intensive outreach services for the homeless using an Assertive Community Treatment (ACT) model.*
   Butte County now has the capability to provide outreach services using ACT components such as small caseloads, frequent or daily team meetings, and frequent client contact. Case managers have learned how to build trust with clients by focusing on the relationship and client priorities.
3. *It is time consuming to find homeless clients in the field.*
   Case managers in these pilot programs spent many hours looking for referred clients in homeless camps and shelters. The design of the REST program, with onsite housing for many clients, will help to address this problem.
4. *The need to pay attention to medical issues.*

[1] Calculating the percentage of SPMI, that are not homeless, and that are in ongoing outpatient mental health treatment, is beyond the scope of this proposal.

This client population is often disengaged from healthcare treatment, as well as mental health treatment. Focusing on medical issues can build trust and prevent future mental health problems.

5. *It takes a special kind of person to do this work.*
   Case managers need to know the community, know available resources, and have a deep desire to help.
6. *Medi-Cal reimbursement policy does not fund outreach activities.*
   With this client population, there is often a long period of trust building before a potential client is willing to sign opening paperwork. This client population often needs case management support to get enrolled in Medi-Cal. These pilot programs did not use Medi-Cal funds. But Medi-Cal helps to fund ongoing outpatient mental health treatment once clients are referred to Butte County services.

In Summary

Conventional services are not effective at reaching and stabilizing this treatment resistant population.
It is estimated that Butte County is currently providing ongoing, outpatient treatment to 19 percent of the severely mentally ill homeless population in the County

Pilot programs targeting this client population can be effective, but are too small and underfunded to solve the problem. The Crisis Triage Connect Team was able to provide temporary outreach services to approximately 25 clients that were high utilizers of crisis services during FY 2020-2021. The Intensive Outreach Pilot targeted 13 eligible clients in 2021.

The multitude of local wildfires, with the additional layer of the global pandemic, are driving an increased need for homeless outreach services that result in coordinated care for our most vulnerable community members. Traditionally, healthcare and social service systems are siloed and this fragmented care is detrimental to patient outcomes and often results in increased costs[3]. Patients receive care through a patchwork of providers at various sites; different locations, staff, systems of care, rules and expectations for clients prevent information sharing and coordination which is critical to whole person care. It is critical for vulnerable and high needs clients to have coordinated whole person care[4]. BCBH's experience in providing intensive outreach services has demonstrated the value and efficacy of an outreach program and broadened our awareness of how many of our community members need these services. The ability to provide services to unengaged individuals that are eligible for services continues to be incredibly challenging with limited staffing and resources.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

Resiliency Empowerment Support Team

The Resiliency Empowerment Support Team (REST) project will build a collective framework to promote engagement in services which will reduce negative outcomes of untreated mental illness and or co-occurring disorders (poor health outcomes, incarcerations; unemployment; prolonged suffering; homelessness). REST will provide intensive outreach and engagement in the community to build trust and promote engagement in Behavioral Health services. The collective framework will consist of a menu of services and support which will include an emergency shelter consisting of sleeping cabins embedded on the Behavioral Health campus, known as Everhart Village. Supportive services available once a potential client is engaged in REST include peer care coordination, SUD service providers, housing case managers, psychiatry and nursing. The REST staff will utilize Ampla Health, a comprehensive healthcare provider in close proximity to Everhart Village, to coordinate medical services REST participants. REST participants will also have access to onsite pharmacy, a community resource center and a computer lab.

For the purposes of the REST project, engagement is both a part of and a result of outreach. When a prospective client is being outreached they are receiving education and information on available treatment services and community resources. Additionally, they are building rapport and trust with the outreach worker. An identified prospective client is considered engaged when they are receptive to the outreach worker and have expressed willingness to be contacted or to meet regularly. They do not have to consent to services immediately in order to be considered "engaged".

Target Population

Individuals who qualify for mental health and/or substance use treatment who are struggling to engage in treatment services. These individuals will be homeless or at-risk of homelessness and most likely be high utilizers of Butte County crisis services, local emergency departments and frequent contact with law enforcement.

High Utilizers of Crisis Services and Inpatient Services

To better understand the utilization of crisis and inpatient services for those who are not engaged in outpatient treatment, BCBH has identified a subset of unserved individuals (individuals who may have a serious mental illness and/or co-occurring disorders). The Department identified these individuals through the following thresholds:

1) individuals experiencing at least three crisis episodes within a 4-week span of time, or,
2) individuals with multiple (2 or more) inpatient hospitalizations in a one-year period, who were not engaged in outpatient services at the time of hospitalization and did not follow up with outpatient services post-hospitalization.

Utilization		Not Engaged in Services	Homeless
Crisis High Utilization *(three or more crisis encounters within a four-week period)*	178	111 people (62.36%) did not engage in services either before or after their high utilization of crisis services	Of the 111 unengaged people, 41 (36.94%) reported being homeless
Inpatient Hospitalizations *(2 or more within one year)*	119	50 people (42.02%) were not engaged in services either before or after their hospitalization	Of the 50 unengaged people, 27 (54.00%) reported being homeless

** Data Collected: April 2020 through April 2021*

Staffing

The REST program will be made up of diverse treatment providers that will address complex behavioral health issues; incorporating intensive care coordination. The already established SEARCH Program Manager will be responsible for continuity of care between REST and SEARCH, and will oversee the REST team. The REST staff will provide field-based outreach and engagement and services onsite at Everhart Village will be provided by a blended team of REST Staff and current FSP staff, depending on the level of engagement of each resident. Stakeholder input indicates that there should be at least one Spanish speaker on the REST team.

Position	FTE	Roles and Responsibilities
Clinical Supervisor	1FTE	Project coordinator for REST, provide administrative and clinical oversight for staff,. Responsible for administration of Innovation project; monitoring the research portion of the evaluation. The ideal candidate will have lived experience in mental illness, substance use or homelessness.
Clinician	1 FTE	Clinical lead, will serve as the warm hand-off from REST to SEARCH by providing comprehensive assessment (including appropriate level of care), treatment planning, individual supportive therapy, and care coordination. Support and guide dual-diagnoses services and monitor outcomes.
Counselors	3 FTE 1 FTE Peer Counselor	Primary focus will be on intensive outreach and engagement in the field, and can provide crisis intervention in the community when appropriate. Will provide case management support, including brokerage and linkage to other community resources and supports. One counselor will utilize lived experience to provide support and care coordination in keeping with the core values, ethics, and best practices of peer service. This counselor will achieve statewide peer certification and will keep an emphasis on the critical role of peers in the delivery of core services. The creation of this hybrid position (Peer Counselor Specialist) will provide capacity building for the peer support role in the department by establishing an enhanced career ladder for peers. This innovation will provide the pilot to establish best practices for peers at varying levels of the organization. These staff are encouraged to become SUD certified at hire or post-hire. Will provide SUD outreach, harm reduction education, overdose prevention education, Narcan education and distribution. Can coordinate access to SUD treatment resources and facilitate recovery support groups. Counselors must be experts in post-Everhart housing placement; landlord engagement, finding housing resources and can establish housing goals. Will be able to assess for vocational readiness and can provide pre-vocational training/education.

Position	FTE	Roles and Responsibilities
Peer Support Specialist	2 Full Time 2 Extra Help	Peers, utilizing a Whole Person Care approach, will be the main source of client support in keeping with the core values, ethics, and best practices of peer service, to coordinate personal care, including physical health, social services, legal services, housing support, medication management. Peer Specialists will guide residents of Everhart Village in developing their own self-directed recovery and resilience plan and support them with strengths-based empowerment strategies for successfully following their plan. Peer Specialists will facilitate a variety of peer led support groups at Everhart Village incorporating strengths-based strategies for encouraging and supporting self-directed recovery and resilience planning. Peers may coordinate access to SUD treatment resources and facilitate recovery support groups. Peer personnel are also encouraged to become SUD certified. Peers will be a component of the field-based engagement and outreach team.
Medical Records Technician	.5 FTE	Provide administrative support by schedule/coordinate meetings and trainings, order office supplies, provide data entry for program evaluation. The other half of this individual's time is spent as the SEARCH MRT.
Administrative Analyst	.5 FTE	Will provide program evaluation
Psychiatrist	.25 FTE	Provides clinical assessments and treatment services to alleviate suffering in clients, or potential clients, with behavioral health disorders. Will address urgent psychiatric needs for individuals in 'pre-consumer status' onsite and in the field.
Nurse	1 FTE	Performs professional nursing duties in the care of mentally ill adult patients; requires a special knowledge of with the laws relating to Mental Health, Drug and Alcohol Services, advises and collaborates with other staff and interdisciplinary health treatment teams in diagnosis and treatment planning for such patients; and, assists and participates in various administrative and mental health program activities. Will address primary health care needs, provide education on health practices and coordinate care with Ampla Health. Must be certified in First Aid and CPR to provide services in the field in collaboration with the Outreach and Engagement Team.

Services

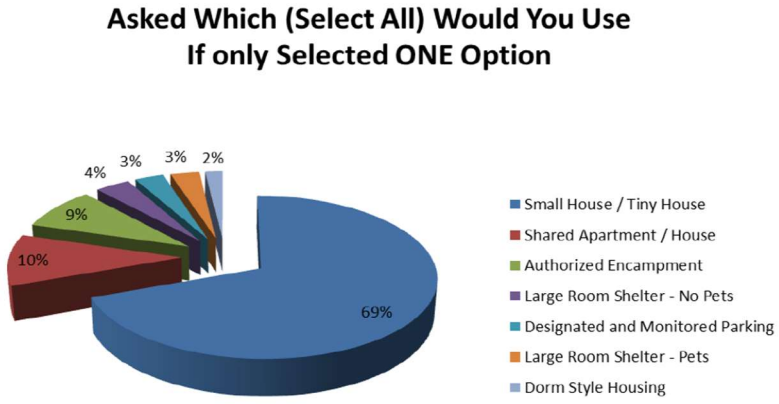
Core services include illness management and recovery skills; side-by-side assistance with activities of daily living; intervention with support networks (family, friends, landlords, neighbors, etc.); support services, such as medical care, housing, benefits, transportation; personal healthcare maintenance, substance-use treatment; employment-support services; case management; and medication prescription, administration, and monitoring. Crisis assessment and intervention will be available, as needed.

Service Category	**Description**
Substance Use Disorder	Outpatient Centers located adjacent to Everhart Village provide assessment, diagnosis, treatment and recovery services to individuals facing substance use challenges, substance use challenges related to alcohol use, narcotic or prescription use, marijuana, and/or stimulant use. Additionally, Narcan will be available and all REST staff will be trained in the administration of this live saving treatment. Field based Medication Assisted Treatment (MAT) refers to a process/procedure where psychiatrists that hold the required Drug Enforcement Agency (DEA) certification (referred to as an x-waiver), to prescribe Suboxone to individuals that may be experiencing acute withdrawal and craving as a result of an opioid use disorder. Enabling field-based prescribing, including induction, stabilization, maintenance, and tapering on Suboxone (or other indicated appropriate MAT medications) enables the team to nimbly navigate co-occurring needs for clients, without the client being required to enter "brick and mortar" location to receive these services. BCBH would like to provide field-based MAT in the REST program, but that would depend on the ability to retain an x-waivered psychiatrist who would be able to implement this service in the field. Otherwise, SUD team members can connect with MAT as indicated, whether with our system of care or other community providers (such as North Valley Indian Health, Ampla Health, Feather River Hospital, Aegis Treatment Centers, etc.) Linkage to MAT services can occur via telehealth when linkages to providers are facilitated.
Mental Health	The Assertive Community Treatment (ACT) model aims to provide mental health care to individuals with serious mental illnesses that impair their capability to live in the community. Because of the severe and challenging nature of their symptoms, these consumers are more likely to: • frequently use emergency and inpatient medical and psychiatric services, • be homeless or live in substandard housing, • be involved in the criminal justice system, or, • use illegal substances. Psychiatrists, nurses, mental health professionals, employment specialists, and substance-use specialists interconnect on ACT teams to give consumers ongoing, individualized care. Consumers receive ACT services in their homes, where they work, and in other settings in the community where problems occur or where support is needed. ACT teams work with relatively small numbers of people for provide personalized care and time unlimited support. ACT teams fit their schedules around the needs of consumers and provide an array of services to help meet consumer needs. Services are available 24 hours a day, 7 days a week.
Psychiatry/ Medication support	Field-based nursing and psychiatry support will be utilized in the field and onsite at Everhart Village with the use of tablets/iPads. Psychiatric assessments and medication support services in the field, in the individual's environment.

Primary Care Coordination	Clients with complex medical conditions will be linked, with the assistance of a Peer Specialists, to Ampla Health for whole person care. Ampla Health is located in close proximity to Everhart Village, and will work closely with the treatment team including the Psychiatrist.

Everhart Village

On June 10, 2020 the County of Butte and Chico Housing Action Team (CHAT), a local registered non-profit, entered into a non-financial agreement for Right of Entry at County owned property 556 Cohasset Road, Chico, for the development of a housing community consisting of 15-20 one-bedroom temporary housing emergency shelter units. The shelter is located on County property adjacent to Behavioral Health clinics in Chico, with Butte County Behavioral Health (BCBH) as the direct referral source. Services nearby include Crisis services, Outpatient Mental Health and Substance Use Disorder services, Iversen Wellness Center, the Crisis Residential Facility, and the 16-bed Psychiatric Health Facility. On September 15, 2020 the Butte County Board of Supervisors approved an agreement between BCBH and CHAT providing Homeless Mentally Ill Offender Treatment (HMIOT) funding in the amount of $175,000 to begin the development of the community. The $175,000 in HMIOT funding was used to purchase a mobile home for community facilities and 8 housing units. Since September 2020, the development of this community has been ongoing. The BOS approved the Site Licensing Agreement on 10/27/2020 and the Project Delivery & Operations Agreement was approved on 4/27/2021.



Everhart Village will offer vulnerable community members a safe and private place to sleep and secure personal belongings, with round the clock supervision and intensive case management. The proximity to Behavioral Health clinics will ensure that clients have easy access to mental health and/or substance use services and supports. The long-term goal is for guests to achieve stability and to move to transitional or permanent supportive housing.

The 2019 PIT data (above) reflects that the local unsheltered homeless population overwhelmingly favors the Small House/Tiny House model for re-entry into housing.

The average length of stay in Everhart Village is anticipated to be 6 months, as Everhart Village is intended to be a stepping stone to permanent housing. Case managers will begin forming a housing plan for the client right away which may include family reunification, locating support systems and potentially facilitating the return to county of origin. Clients will be referred to Everhart through the BCBH Client Transition Services (CTS) meeting, which is a weekly work group to support and facilitate the coordination and collaboration of providers addressing the placement and service delivery needs for youth and adult clients within the Behavioral Health system of care. It is expected that the once CTS approves the referral for Everhart Village, the turnaround time for an intake appointment with CHAT is 1-3 working days. The client's case manager will accompany the client to Everhart Village to meet with Village manager and begin the intake process.

While Behavioral Health has committed to provide supportive case management to the residents of Everhart Village, the expansion of this program through Innovation funds will provide the opportunity to explore the research questions.

Once housed in Everhart Village, individuals can begin their journey towards mental wellness and rehabilitation through direct support from an innovative team; the Resiliency Empowerment Support Team. Community members will be able to access the REST program whether or not they are housed at Everhart Village.

On-site Amenities for REST Participants

Computer Lab

A computer lab be incorporated in the already established Behavioral Health campus, which is adjacent to Everhart Village. This computer lab will provide REST participants with access to the internet and therapeutic art activities. The therapeutic art curriculum will be determined by the REST Supervisor.

On-site Pharmacy

Genoa will operate a pharmacy that specializes in mental health, including pharmacists with specialized in mental health. Genoa can offer injection clinic, and one-stop-shop for individuals on site and their medication needs.

Community Resource Center

The Everhart Village Community Building will be the main gathering space and will house basic needs services. The Community Resource Center will have two offices for clients to privately meet with case management, along with a kitchen, recreation room, showers, and laundry machines to help serve the needs of each person in the program. The Community Building is diverse in what it will offer and will ensure the growth of independence of those who use it.

Program Operation

Intensive Outreach and Engagement

An integral part of this Innovation project is the homeless Intensive Outreach Team (IOT), which will operate 7 days a week. This team will be made up of counselors, a peer counselor and peer support specialists who will offer a physical presence in the homeless community to provide supportive counseling, education, and assistance in accessing services. They will work to build rapport and trust with homeless individuals, linking them to medication, shelter care, housing, and other community supports.

Intensive outreach and engagement services are for mentally ill individuals (age 18 and over) who are likely to benefit from intensive outreach 3-4 times a week. Individuals facing chronic homelessness typically do not self-refer to behavioral health services due to stigma, fear, or lack of insight into their condition. Flexibility will be the norm rather than the exception for IOT interventions. Typically, the first 30 days of outreach and engagement are used to triage and determine eligibility, however, this team may triage beyond the initial 30 days and up to 6 months, as appropriate. The flexibility of this program is a significant differentiation between Assisted Outpatient Treatment (AOT), also known as Laura's Law. REST will have most of the characteristics of AOT, but most importantly, the ability to serve a wider range of community members, in addition to those who would qualify for Laura's Law.

To avoid attaching stigma to services, the IOT staff will not wear badges or identifiable County clothing so they can blend in better. Peer support specialists will be integrated into the teams to provide hope, model recovery, actively coach, engage and connect with potential clients. The IOT staff will have funds available to aid in the development of relationships and trust in the Department. Potential uses of these funds include coffee, food, blankets, socks and hygiene supplies as part of IOT's "whatever it takes" strategy to promote essential relationship building and provide recovery-oriented interventions.

The primary goal of outreach will be to successfully engage the community member into voluntary services and connect him/her with the appropriate level and type of care. IOT will be coordinated by a Behavioral Health REST Supervisor, who will also act as the Lead, and will act in partnership with the adult full-service partnership program, known in Butte County as SEARCH (Support, Engagement, Advocacy, Recovery, Community, Housing).

One Program Manager will oversee SEARCH and REST to ensure continuity of care and seamless collaboration. There will be instances when a potential client has agreed to enter into services, but may still be reluctant to engage fully with, and agree to, their treatment plan. These clients will be deemed as "in-progress" and services with REST and the SEARCH team will overlap to provide team-based care to address identified barriers to complete engagement.

BCBH will be accepting referrals from the community or family members and then outreaching to those individuals. The Department recognizes the value and importance of working with the family or significant others throughout the referral and treatment process, and will attempt to gain the community member's permission to communicate regarding the progress and provisions of care that are being provided or coordinated. At all times referred community members will be treated with dignity and respect. The team will have the capacity to be responsive to the community member's cultural and linguistic needs.

All services provided to a community member will be recovery and wellness oriented and will consider all aspects of the person's well-being (mental health, physical health, substance use disorders, social support etc.). All clinical Assessments will be conducted in the least restrictive environment possible and every attempt will be made to meet with the community member in their preferred environment/location. The IOT staff will be responsible for ensuring that the referred individual's rights are protected, and will provide appropriate advocacy resources. It is imperative to prioritize avoiding hospitalization and maintaining autonomous housing for this difficult to engage population.

The IOT team members will be required to attend a Nonviolent Crisis Intervention Foundation Training Program (CPI) provided by Butte County Behavioral Health in order to maintain personal safety in escalating situations. This training will include tips for recognizing early signs of crisis, strategies for appropriate crisis intervention at each stage of escalation, strategies for quick decision making and will honor and acknowledge staff fear and anxiety while emphasizing safety for all involved parties.

The ACT model helps service providers (IOT team) to understand the risk management that is at the heart of daily decisions. The team culture of dialogue, and social cohesion among service providers seem to be protective factors in the evolution of risk analysis and subsequent measures that are put into place to ensure engagement occurs. The ACT model calls for a very cohesive team of psychiatrists, nurses, clinicians, counselors, and peers where their knowledge and concerns are heard informally in daily meetings. Internal decision making is horizontal, and service providers themselves often challenge the use of diagnostic language.

Referral Process

Referrals to the REST project will be made via phone through the BCBH Access Line or by submitting a REST referral form to the Access Team's email. Referrals can be generated by community members and the BCBH IOT through street outreach activities. The already established Access Team ensures all referrals are connected with the appropriate resources and they will send the REST referral to the REST Supervisor for further screening. The REST Supervisor contacts the referring party to gather information to aid in the engagement process to individualize services with the community member, and to gather any other pertinent information.

Eligibility Criteria

Potential clients will be referred to the REST program if:

- ✓ The person is 18 years of age or older.
- ✓ The person appears to be suffering from a mental illness as defined by Welfare and Institutions Code (WIC) 5600.3(b)(2)-(b)(3) and appears to meet Specialty Mental Health Services Medical Necessity.
- ✓ The person has been offered an opportunity to participate in outpatient treatment, and the person continues to fail to engage in treatment.
- ✓ The person is reasonably believed to be present/residing in Butte County.

AND meet one or more of the following criteria:

- ✓ The person's mental illness appears to meet criteria for serious persistent mental illness (SPMI), placing them at risk of psychiatric hospitalization, or receipt of crisis, or other outpatient mental health services.
- ✓ The person's mental health condition appears to be substantially deteriorating and requires intervention.
- ✓ It is likely that the person will benefit from Intensive Outreach services.

Enrollment

Once it has been determined that the referral is appropriate and meets criteria for the REST program, the REST Supervisor assigns specific REST staff to begin the engagement process. For purposes of this document, once the referral is received by the REST Intensive Outreach Team (IOT), the person is known as a REST "Candidate".

- ✓ IOT staff will respond within 3 days to "Candidate's" condition with an initial intervention and offer voluntary services, including but not necessarily limited to REST services and shelter at Everhart Village, if appropriate. At least 3 attempts per week will be made to engage the "Candidate" and encourage voluntary participation in a mental health outpatient Full Service Partnership program, SEARCH. All attempts will be clearly documented.
- ✓ If "Candidate" meets criteria and accepts voluntary treatment, IOT staff will provide warm hand off to SEARCH. REST staff will remain on the treatment team for up to 6 months to ensure the candidate engages in SEARCH services.
- ✓ If after 30 days (or any subsequent time during the initial outreach period), the IOT staff has determined that "Candidate" does not meet criteria, The REST referral will be reviewed at CTS and if agreed upon, the case will be connected to outpatient services or referred out and closed.
- ✓ If after 90 days of outreach and engagement "Candidate" continues to meet criteria for services but continues to refuse services (or at any time the REST team feels that the "Candidate" is decompensating and requires a 5150 assessment), or within 6 months of agreeing to any service offered as part of this initial intervention, the "Candidate" refuses services, the REST Supervisor will be notified and, if needed, a Multidisciplinary Team meeting will be scheduled.
- ✓ IOT staff will meet daily to weekly with the REST Supervisor during the engagement phase to discuss cases and problem solve.
- ✓ CTS addresses the most efficient and least restrictive level of treatment/placement, to maintain community placement, maintain progress in achieving expressed goals, and ensuring continuity of care. This is where all supportive housing resources, including Everhart Village, should also be discussed.

Everhart Shelter Referral

If the candidate is being referred to Everhart Village, a CHAT representative shall be invited to attend the CTS meeting. REST shall be responsible for obtaining Release of Information for CHAT prior to CTS meeting. CTS meetings are typically held once a week on Wednesdays, but emergency CTS meetings relating to Everhart may be convened or held virtually (via email), as necessary.

- Prior to attending CTS meeting:
  - The Everhart Referral Form will be a fillable PDF saved in a shared location, which will be emailed to CTS MRT 24 hours prior to CTS meeting, allowing time to review needed documentation and answer any remaining questions. This allows for efficiency and processing volume of referrals.
- If a candidate has been accepted for shelter at Everhart Village, the Everhart Village referral will be provided to CHAT. The REST case manager will accompany the client to Everhart Village to meet with Village manager and CHAT will then begin the process of intake for Everhart Village.
  - It is expected that the once CTS approves the referral for Everhart Village, the turnaround time for an intake appointment/walk-in with CHAT is 1-3 working days. Referrals cannot sit, they must be approved or denied at CTS.

Continuous Quality Improvement

Programs supported by the MHSA must collect data on performance measures.[5] Systems for collecting performance data are now well established in the Department. This is evidenced in the existence of the System Performance, Research and Evaluation (SPRE) Unit. The SPRE unit is responsible for conducting program data collection, data reporting, program planning, research, and evaluations, as well as in-depth analysis of behavioral health programs and the operation of the service systems that they support. Analysts in this unit possess a strong technical skill set that is used to not only promote the collection of data in the agency's Electronic Health Record (EHR) by designing targeted data-entry screens and protocols, but also they have conversancy with myriad data extraction and reporting applications that permit them to pull raw data from the EHR and assess and translate findings into clear and concise information for non-technical audiences. The SPRE Unit will be intricately involved in all aspects of data collection and analyzation for the REST Project.

It is therefore appropriate for BCBH to take the next step and focus on helping staff to use performance data to improve quality and drive innovation. Butte County can advance the management practices of other county behavioral health departments by becoming a leader in continuous quality improvement (CQI). CQI in the REST Program will involve three main components: performance measurement, innovation, and benchmarking.

Performance measurement – This component consists of two steps: 1) developing measures of program activities and outcomes, and 2) developing systems for easily capturing and summarizing these measures. Quality Management and the Systems Performance, Research and Evaluation (SPRE) Unit will help REST to develop measures of program activities and outcomes with a focus on measures related to client engagement. REST will utilize Butte County's Avatar EHR system for capturing most data elements.

Interpretation and Change – This component involves front-line staff in data feedback, interpretation, and developing improvements. The specific steps include 1) providing process and outcome data to treatment teams; and 2) team meetings in which participants make sense of the data, reflect on factors driving results, and identify adjustments that could improve results. Butte County's SPRE will design reports forms for Avatar that will allow staff to easily pull specified data sets. Quality Management will provide training to REST staff on how to have productive conversations about performance data, including how to identify performance gaps, and how to implement Deming's Plan-Do-Study-Act (PDSA) cycle for solving problems and managing change.[6] The application of these skills in team meetings helps programs to benefit from the detailed knowledge of front-line staff about clients and program processes.[7]

Benchmarking – REST staff will benchmark their processes and results against other programs treating similar client populations. This process will include site visits to better understand how best practices are achieved.[8]

A. *Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.*

Introduces a new practice or approach to the overall mental health system, including, but not limited to, participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite.

B. *Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied*

The community has strongly supported the design and development of the REST project. This project began with support surrounding the "Simplicity Village" concept and has evolved over time to "REST at Everhart Village".

Stakeholder feedback has informed the decisions for a "no wrong door" approach and identified the target population. There have been ongoing issues with locating appropriate supportive housing for SMI population and clients are too symptomatic and need support to navigate the COC Coordinated Entry process. BCBH has a high population of FSP level of care clients that are homeless where the housing uncertainty continues to affect any progress or attempts at mental health stability.

C. *Estimate the number of individuals expected to be served annually and how you arrived at this number.*

The Intensive Outreach Team (IOT):

There will be one team that covers the entire County. This team will be located in Chico, but will provide outreach to any location in Butte county and will be primarily field based. The IOT will have 1 Supervisor, 1 Clinician, 3 counselors, 1 counselor peer specialist, 2 full-time peers and, in addition, access to extra help peers, and a nurse and psychiatrist on an as needed basis.

The estimate of individuals served is based on the following assumptions:

- The team will have a caseload of 20 clients for 6 months;
- 20 clients every 6 months x 2 = 40 clients every 12 months;
- Assume 4 clients per year dropping out, freeing up an additional 4 slots;
- 40 clients + 4 replacement clients = 44 clients per year.

This caseload was deemed appropriate when considering the 3-month IOT pilot that the Department implemented in early 2021. Therefore, it's anticipated that IOT will be able to accept 44 referrals from the community, per year. It is estimated that 22 of those referrals will enter into BCBH services.

REST In-Progress:

There will be instances when a potential client has agreed to enter into services but may still be reluctant to engage fully with, and agree to, their treatment plan. These clients will be deemed as "in-progress" and services with REST and the SEARCH team will overlap to provide team-based care to address identified barriers to complete engagement. In this instance, REST IOT Counselors will provide case management services with the oversight of the REST Clinician and carry the "in-progress client" as a part of their caseload until full transition into services is complete. The Department is estimating that there may be one or two clients "in-progress" per IOT counselor, per year. Therefore, it's anticipated that REST will carry no more than 8 "in-progress' clients per year on their caseload.

Everhart Village

The average length of stay in Everhart Village is anticipated to be 6 months, as Everhart Village is intended to be a stepping stone to permanent housing. There will be 15 sleeping cabins (with the potential to increase to 20 sleeping cabins) available for residence, therefore it's anticipated that there will be 30 individuals residing at Everhart, per year.

D. *Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).*

The population served will be Butte County residents who are eligible for behavioral health services, are homeless or at-risk of homelessness, and refuse to engage in services for a multitude of mental health reasons. This population must be 18 or over and may speak the County threshold languages; English or Spanish. Although Hmong is not a threshold language in our County, BCBH strives to provide access and resources to the Hmong community in their native language due to the large Hmong presence in Butte County.

Race	Percentage Distribution
White	71.6
Black or African American	1.8
American Indian and Alaska Native	2.5
Asian	4.9
Native Hawaiian and Other Pacific Islander	0.3
Two or More races	4.6
Hispanic of Latino	14.3

While most of Butte County can be considered homogenous in its racial diversity there are burgeoning ethnic communities and economic opportunities that have characterized Butte County's importance as a cultural and economic hub in Northern California. Large Spanish speaking and Hmong communities call Butte home. There are currently four Rancherias in the area, Berry Creek Rancheria; Mooretown Rancheria; Enterprise Rancheria; and, Chico Rancheria.

Additionally, BCBH acknowledges that LGBTQ+ individuals are considered particularly vulnerable to experiencing homelessness. Research shows that LGBTQ populations encounter higher rates of homelessness and trauma due to family rejection/conflict and lack of appropriate supports or interventions. Transgender and gender non-conforming adults who experience homelessness encounter several challenges in the homelessness system, particularly in regard to safety and gender-affirming supports. Transgender individuals also face challenges with other residents at shelters, making them more reluctant to move indoors. For more information on BCBH's strategy to appropriately serve this population, please see Cultural Competency under MHSA General Standards.

RESEARCH ON INN COMPONENT

A. *What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?*

What is Innovative about REST?

The innovation is the many features of this project that, when considered collectively, promote continuity to the community which has not been seen in a rural setting.

1. Meeting people where they are by taking services to them, reducing individual or provider level barriers to services.
    - This program invites participation and partnership instead of demanding compliance.
2. Co-location of tiny homes and Behavioral Health campus in a rural county.
    - Traditionally these services are not co-located in a rural county; this will eliminate barriers (proximity, transportation) and silos in between service providers.
3. Co-location of integrated health services with a focus on whole person care.
    - Traditionally these services are not co-located in a rural county; this will eliminate barriers (proximity, transportation) and silos in between service providers.
4. Engaging the community to help connect with unserved individuals who are eligible for services.
    - Community members are often more aware of individuals who would benefit from intensive outreach and engagement.
    - Friends and family are eligible requesting parties for potential candidates.
5. Intensive outreach and engagement team with flex funding for incentives to meet people where they are at.
    - Utilizing flex funding to support basic needs in order to build rapport has not typically been a strategy used for individuals who are resistant to treatment.
6. This model pivots to a proactive and preventive stance, to engage underserved individuals who are not able to seek services independently due to barriers.
    - The target population is people who are not engaged in behavioral health services.
    - The traditional public mental health system serves populations who have some awareness of their severe mental illness and are seeking services.

7. Emphasis on the critical role of peer support.
    - Historically in Butte County, peer support services have been underutilized and have not been used for intensive outreach to assist in engaging people who are difficult to engage.
    - The Department will benefit from the value of peer support by utilizing the upcoming Peer Certification and variety of associated trainings in Best Peer Practices and Specialization.
    - Peer Counselor Specialist will be a new position within the Butte County system of care.
        - One counselor will utilize lived experience to provide support and care coordination in keeping with the core values, ethics, and best practices of peer service. This counselor will achieve statewide peer certification.
        - The creation of this hybrid position will provide capacity building for the peer support role in the department by establishing an enhanced career ladder for peers. This innovation will provide the pilot to establish best practices for peers at varying levels of the organization to ensure collective and individual growth in expanding peer roles over time.
8. Continuous Quality Improvement.
    - Providing process and outcome data to treatment teams; and
    - Team meetings in which front-line staff make sense of the data, reflect on factors driving results, and identify adjustments that could improve results.
9. This project strives to identify and overcome individual and provider level barriers to engagement in services:

Identified Barriers (Page 2)	**Innovative Solution**
Stigma	• Intensive outreach and engagement, with an emphasis on peer support specialists, to provide outreach in the community to build trust and relationships. • Peers who have lived experience increase trust with service providers which will address barriers related to stigma.
Mental health symptoms	• Intensive outreach and engagement, with an emphasis on peer support specialists, to provide outreach in the community to build trust and relationships.
Practical	• This service model will break down silos within the array of medical and social services, including access to onsite pharmacy • Providing services in the community, or where people live, rather than at a clinic facility • Seamless continuity of care and integrated services breaks down barriers • Providing urgent psychiatric services, in the field, where they are at • REST will serve anyone regardless of payer source until the individual is linked to the appropriate social service.
Social	• Community environment integrated at Everhart Village to enhance quality of life • Collaboration with community resources within a social work framework • Increased flexibility in service delivery
Complex health issues	• Medical services to address physical health management imbedded at Everhart Village and provided in the field

Identified Barriers (Page 2)	Innovative Solution
	• Access to Ampla Health services for medically compromised/complex situations, including access to onsite pharmacy • Intensive case management to help clients build health management skills • Developing self-awareness about medical needs • Full medical screenings and connection to primary care for needed follow up care and coordination with Psychiatry
Homelessness	• Everhart will provide a safe and secure place to live so that basic needs are addressed so that community members can focus on behavioral health needs. • Community members with a consistent residence would benefit from outreach efforts to engage them and to coordinate their entry into services • Increased support and case management services (including WRAP groups) at Everhart Village
Substance Use Disorder Treatment	• Increasing capacity with SUD trained staff within the team, would increase capacity for outreach, access, linkage, and SUD capable services within one treatment team. • The outreach team would continue to have access to the entire continuum of SUD treatment services, and would be able to engage the client "where they are at," increasing the likelihood that the beneficiary would continue with outpatient services.
Community Reported Barriers	• REST will provide a wide array of services to treat the whole person all in one place so access to care is not an issue • The community identified 1) access and 2) transportation as barriers and this project eliminates those barriers by being field-based and providing services at the site of the shelter housing

Literature Review

This literature review focuses on client engagement, which is the core of the REST project. The following questions, related to client engagement, are explored:

1. How is engagement portrayed and operationalized in the research literature?
2. Is assertive outreach a good model for engaging difficult to engage clients?
3. What are good practices for engaging the severely mentally ill in treatment?
4. Can continuous quality improvement improve client engagement?

1. How is engagement portrayed and operationalized in the research literature?

The term, "engagement," is used inconsistently in the literature on intensive case management.[9] Hendersen and colleagues characterize the many ways engagement has been portrayed including, "accessing services, retention within services, enthusiasm and self-management, service provision and the interaction between the patient and healthcare provider."[10] Other researchers have emphasized understanding the need for treatment, compliance with treatment, and the relationship dimensions of trust and rapport.[11]

In most outcome studies on Assertive Community Treatment (ACT), engagement is defined in terms of remaining open to the ACT team itself, e.g. the percentage of clients remaining in treatment,[12] or the number of days in treatment.[13] Engagement can also be defined by looking at the utilization of services not provided by the ACT team, such as, utilization of outpatient mental health (number of days in treatment)[14] or of outpatient medical services (number of contacts in a defined period).[15] This approach is of particular relevance to the REST project which has, as its main purpose, connecting clients to outpatient mental health and health services.

TABLE 1. ENGAGEMENT DIMENSIONS IN TWO STANDARDIZED INSTRUMENTS

The Engagement Measure (Hall et al. 2001)[16]	The Service Engagement Scale (Tait et al. 2002)[17]
• appointment keeping • client-therapist interaction • communication/openness • client's perceived usefulness of treatment • collaboration with treatment • compliance with medication	• availability • collaboration • help seeking • treatment adherence

The most comprehensive portrayals of engagement are provided by standardized measures. Researchers have developed standardized instruments based on the perspectives of providers,[18] and clients.[19] A summary of the dimensions measured by two standardized scales is shown above in Table 1. A standardized instrument will be used by REST staff to track and monitor engagement efforts.

2. Is assertive outreach a good model for engaging difficult to engage clients?

The REST Project will use Assertive Outreach embedded in Intensive Case Management to engage difficult to engage clients with serious and persistent mental illness. There is a broad consensus that clients with serious and persistent mental illness should be treated in the communities in which they live, rather than by hospitalization and hospital aftercare programs (to prepare them for the community).[20] There is debate in the research literature on how closely programs should adhere to the specific components of strict Assertive Community Treatment (ACT).[21] The ACT model involves treating people in the community with assertive outreach, assessment, training, and support using the following guidelines:

- Multidisciplinary staff mix who operate using a team approach;
- Daily or frequent coordination meeting for all patients;
- Low patient to clinical staff ratios e.g. 10:1, 12:1;
- Low team case load e.g. 75;
- Holistic approach of providing many care elements by the ACT team rather than outside referrals;
- Target population: severely mentally ill population only.[22]

The assertive outreach/intensive case management to be used in REST is close in structure to ACT. Therefore, research on ACT provides a reasonable approximation of the results that can be expected in REST. Intensive Case Management (ICM) is similar to ACT in structure, but is more flexible.[23] Among studies defining engagement in terms of treatment retention, ACT has performed better than standard care.[24] Two studies targeted clients with substance use disorders in addition to severe mental illness. After 18 months of treatment, 65 percent of the ACT group was still in treatment, compared to just 40 percent for controls.[25] In another study of dual diagnosis clients with severe mental illness, researchers reported much longer participation in treatment in the ACT group (335 days), compared to the treatment as usual group (96 days), over a 12-month period.[26] Excellent engagement results were also reported in a German study of clients with psychosis, and using a version of ACT tailored for psychosis.[27] The researchers reported, for a four-year time period, only 13 percent dropping out "for non-practical reasons."[28]

ACT has also performed better than standard care when engagement is defined in terms of participation in outpatient mental health or outpatient health services. Studies on clients with substance dependence and severe mental illness report higher use of outpatient substance use services (6.9 services in 6 months compared to 2.0 in

the TAU group),[29] and better engagement in mental health services (305.5 days in treatment compared to 169.4 in the standard care group).[30] A team from the Netherlands studied a less standardized version of ACT, Flexible ACT (FACT), and reported more frequent outpatient health contacts in the FACT groups over a one-year period (7.9 visits), compared to controls (1.6 visits).[31] In conclusion, whether engagement is defined in terms of participation in case management itself, or in terms of participation in outpatient services, intensive case management/ACT performs better than treatment as usual for hard to engage populations.

3. What are good practices for engaging the severely mentally ill in treatment?

The research on ACT includes qualitative studies on good practices for fostering/facilitating engagement. These studies are based on perceptions of ACT clients,[32] and ACT providers.[33] There is agreement in the literature that building a trusting relationship with the client is a key task.[34] There is also agreement across studies that building a productive, trusting relationship involves acceptance, respect for client choices, persistence, and viewing the client as a whole person.

Good Practice #1. Acceptance and Respect for Client Choices.

Providers interviewed in multiple studies convey the need to respect client choices because clients have rights,[35] because of an attitude of working for the client,[36] and an emphasis on meeting clients where they are.[37] This practice includes working at the client's pace, which can be experienced as slow.[38] This good practice is consistent with the Motivational Interviewing philosophy of respecting client autonomy, acceptance, collaboration, and meeting clients where they are.[39]

Good Practice #2. Persistence.

Another consistent, robust finding in the research is the need for persistence in developing engagement with the severely mentally ill.[40] Persistence is needed because building trust and rapport with this client population takes time.[41] "With a lot of our clients, initially, they don't want any kind of contact with us whatsoever, and we come out regardless of how many times they slam the door in our face. We do it consistently" [42]

At the start of engagement efforts, clients frequently perceive the ACT team's overtures as odd and intrusive, but being patient and persistent often paid off.[43] From the perspective of various clients,

- "They did not give up, and they put a lot of effort into it. I was not cooperative in the beginning."
- "In the beginning, I thought they (ACT), were too involved. But after a while it somehow smoothed out… Now, I have mostly positive experiences with ACT, because I realize they are people of good will… But it can feel like surveillance."
- "I was very skeptical and thought it was some kind of trick. Eventually I realized it was a kind of self-help offer. I really appreciated it, because then I had someone to lean on. I felt so alone with my problems [before the ACT team's interventions]."[44]

Persistence is an essential good practice because clients report that it takes time for them to gradually recognize the provider's good intentions.[45]

Good Practice #3. Managing the Tension Between Persistence and Respecting Client Choices

It is a delicate balance to persist long enough in the face of client ambivalence or rejection to build trust but also respect client rights and autonomy. It is necessary for providers to judge whether to keep persisting in the face of rejection.

- ''We realized it was down to the point where she was consistently saying she did not want services, so then we have to respect that. At some point, we have to respect her choice.''[46]

Providers often encounter rejection and hostility when first trying to meet with certain clients.[47] Providers in one study explained,

- "Just because I'm working in assertive outreach…. you can't force someone to like you, and I think sometimes you've got to wrestle with that."[48]

The reviewed research illustrated the nature of the tension between persistence and respecting client decisions. However, a gap in the reviewed literature is a lack of specific guidelines for resolving this tension. The REST program, with its engagement focus, has a chance to provide guidelines on how to manage this delicate balance.

Good Practice #4. Seeing the client as a Whole Person

The importance of a whole person view is expressed in various ways in the literature on engagement, including seeing client as a person and not just their diagnosis[49] and seeing clients as individuals that deserve treatment and not just part of a job.[50] Providers identified specific techniques for putting this value into practice through making the client's interests a main focus, engaging clients in social activities together, and making the establishment of a trusting relationship a primary goal.[51]

- "...it's futile to just talk about illness and medication when there's so much more to a person.''[52]

This philosophy is also facilitated by the practice of seeing people where they live, which helps providers to understand the many factors influencing the client.[53]

- ''When you get to go out and be in their natural environment and see the stresses and the family and the conditions they have to exist within, it adds a whole new light to just what you see on their axis diagnosis..."[54]

Clients report wanting to be pursued, treated respectfully, and feel that they were chosen because they do have a chance to get better.[55]

Good Practice #5. Peer Support Specialists to Enhance Engagement

The term "peer support," in the provision of mental health services has multiple meanings. One meaning is the mutuality of lived experience by the peer support specialist, which may allow more authentic empathy and validation.[56,57] Another meaning is the greater focus on self-directed wellness and recovery, as opposed to symptoms and fixing problems.[58]

Researchers at Yale and the University of California, San Francisco, compared engagement in peer-based and regular case management teams.[59] The clients in the study reported greater positive regard, understanding, and acceptance, from the Peer Support Specialists at the six-month interval. This difference disappeared at the 12-month interval. But, the greater engagement of clients at the six-month interval predicted greater motivation for psychiatric and substance use treatment and greater motivation for attending Alcoholics Anonymous and Narcotics Anonymous at 12 months. In addition, the Peer Support teams were more effective at increasing treatment engagement among the least engaged clients.

Research on providers in an ACT team in Virginia suggests how peer support specialists might enhance engagement on intensive outreach teams.[60] Team members reported that peer support specialists, "can connect with clients in ways other staff cannot."[61] The peer support specialists helped outreach teams to understand client needs and perspectives, and clients viewed the peers as advocates and role models.

4. Can continual quality improvement improve client engagement?

County mental health departments are required to be data-driven.[62] They are measuring processes and results and providing this information to leadership and to funding agencies. Very few county mental health departments, or community mental health agencies, that we are aware of are providing data on a frequent, regular basis to front-line treatment teams to drive continuous improvement. The available research indicates that such an approach could be effective.

Systematic research reviews on continuous quality improvement (CQI) in mental health have generally found small, but consistent benefits to providing clinicians with data on treatment outcomes. An early meta-analysis of controlled trials found small, but statistically significant benefits on the mental health of the clients, in the short-term, but not the long-term.[63] A more recent systemic review found that a majority of clients in the feedback

systems had significantly higher treatment gains than patients in the non-feedback systems.[64] Two research reviews found that feedback on outcome measures was especially effective with not-on-track clients.[65]
Two systemic research reviews found that 70 percent and 56 percent (respectively), of clients in the feedback systems had significantly higher gains on at least one treatment outcome than patients in the non-feedback systems.[66] So far, feedback to clinicians on outcomes has not shown consistent positive impacts on treatment costs.[67]
Research has identified practices for CQI that are correlated with improved outcomes. Providing feedback to both the clinician and the client, and not just to the clinician, was supported in two reviews.[68] Providing feedback more frequently has statistically significant benefits.[69]

The existing research on CQI in mental health addresses therapists providing psychotherapy to relatively high functioning clients. Quality Management could not find research on using CQI for intensive case management with the severely and persistently mentally ill. Quality Management could not find research on using CQI to address the challenge of engaging this client population. The REST project will start to address these gaps by implementing CQI with intensive case management treatment teams and monitoring the results. REST treatment teams will be provided with data on the number of outreach attempts, connections with outreach staff, and enrollment in needed outside services. The Service Engagement Scale will be administered and reported out to treatment teams on a monthly basis.[70] REST treatment teams will meet and reflect on this data on a bi-weekly basis. Quality Management will help REST treatment teams to use total quality management tools such as cause-effect charts and scatter plots to facilitate experiments and continuous process improvement.[71]

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

The learning goals for the REST project are based on the logic of how project activities are converted into outcomes. A logic model for the project, illustrating the hypothesized causal connections between project activities and outcomes, is shown below in Table 2.

Table 2. REST Program Logic Model

PROJECT ACTIVITIES	DIRECT PRODUCTS	SHORT-TERM OUTCOMES	INTERMEDIATE OUTCOMES	ULTIMATE OUTCOMES
Screen potential clients Intensive outreach Services • Support • Referrals Innovative programming • Whole-person care • Peer Support Specialists • Continuous Quality Improvement	Client **engagement** in intensive outreach Client **enrollment** in • Mental health • Medical health • Job-seeking/job training • Everhart Housing	Client **engagement** in essential services • Mental health • Healthcare • Housing • Employment & Training • Public Benefits	Improvement in mental health symptoms Substance use down Improvement in functional impairments	Stable long-term housing outside the program Crisis evaluations down Psychiatric hospitalizations down Arrests down Stable employment

The REST project activities include screening clients, intensive outreach and engagement through innovative programming. If these activities are performed well, then the following direct products will follow: client engagement in intensive outreach services and gradual enrollment in needed services. If the direct products are effective then clients will become engaged in needed services (the short-term project outcome). The intermediate and ultimate outcomes address results that clients will achieve after leaving REST. But, they are still relevant to the evaluation, because they are results that clients will have achieved because of the project's role in connecting them to outside services.

Following the logic model, the learning goals for the REST project can be grouped into three categories: short-term outcomes, intermediate outcomes, and ultimate outcomes.

SHORT-TERM OUTCOMES

Learning Goal 1. Intensive Outreach - Is intensive outreach effective for engaging the target population in services?

Learning goal #1 was selected because intensive outreach is the core process of the Project for engaging clients. Learning goal 1 captures the following innovative project elements: meeting people where they are, flex funding to support basic needs and build rapport, and peer support specialists to facilitate engagement.

Learning Goal 2. On-site housing – Does on-site housing facilitate client engagement?

Learning goal #2 tests the hypothesis that co-location of tiny homes will help the target population to overcome key barriers to engagement in needed services. Co-location of tiny homes is also an innovative project component.

Learning Goal 3. Comprehensive - Is the overall REST approach of intensive outreach, coordinated care, and onsite housing, effective for engaging the target population in services?

It is important to know how the project package, as a whole, is succeeding at its core purpose of improving client engagement in needed services. This learning goal captures the synergies of all of the project components working together to enhance client engagement.

Learning Goal 4. **Learning** - Does continuous quality improvement improve program and clinical practices and thereby improve client engagement?

This learning goal tests the hypothesis that the front-line staff on quality teams have detailed knowledge about their work that is useful for improving client engagement. C*ontinuous quality improvement is also an innovative project component.*

INTERMEDIATE OUTCOMES

Learning Goal 5. Reducing Symptoms and functional Impairments - Will Butte County Department of Behavioral Health (DBH), be able to help the REST target population with mental health, substance use, and functional impairments?

A concern in focusing on the most difficult to engage clients, is whether this client population can make gains in treatment. If the clients referred from the REST project can reduce their mental health symptoms, substance use disorders, and functional impairments (intermediate outcomes), that helps to justify the efforts made by REST to engage them.

ULTIMATE OUTCOMES

Learning Goal 6. Changing lives - Will Butte County Department of Behavioral Health (DBH), be able to help the REST target population to obtain stable long-term housing, reduce its utilization of crisis services and hospitalizations, lower arrests, and raise employment?

If REST clients are able to obtain stable long-term housing, reduce utilization of crisis services and hospitalizations, have fewer arrests, and improve employment rates, that indicates that it is possible to help difficult to engage clients. In addition to the outcomes described here, REST will involve front-line staff (including Peer Support Specialists), and beneficiaries, in defining other outcomes and outcome measures. The types of outcomes and outcome measures that will be developed through a participatory evaluation process cannot be specified in advance, but could include stigma reduction and improvement of mental health systems.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

Learning Goal 1. Intensive Outreach *- Is intensive outreach effective for engaging the target population in services?*

The process (independent) variables for this learning goal are:

- Intensive outreach services;
- Client engagement in intensive outreach services;
- Client enrollment in needed services.

The outcome (dependent) variable for this learning goal is:

- Client engagement in needed services.

Measures for the above process and outcome variables are shown in Table 3 below. A more detailed description of measures and data sources is given in Appendix A.

TABLE 3. VARIABLES AND PERFORMANCE MEASURES

Goal	Interventions	Measures of Program Processes	Performance Measures (Outcomes)
SHORT-TERM OUTCOME: Client engagement in needed services	1. Intensive outreach services; 2. Client engagement in intensive outreach services; 3. Client enrollment in needed services.	# of outreach attempts per client (per week) # of client connections per client (per week) Score on the Service Engagement Scale (every 30 days) # of enrolled services per client / # of needed services per client	# of engaged services per client / # of needed services per client Performance target: 0.75

Project monitoring for Learning Goal Number 1.

REST will monitor (1) the program process variables to ensure that the project is being fully implemented; (2) client engagement in needed services to identify needs and trends, and (3) the time it takes to enroll and engage clients in needed services.

Evaluation for Learning Goal Number 1.

The impact of intensive outreach on engagement can be measured with a regression equation of the following form:

Engagement rate = outreach effort + outreach time + outreach effort x outreach time.

An interactive variable is used for outreach time and effort since the impact of each of these on engagement, depends on the value of the other.

Interpreting the results
Statistically significant coefficients for the outreach variables and/or significance for the interaction term would support the hypothesis that REST intensive outreach is impacting client engagement.

REST will also evaluate the value of the engagement variable. The target performance level will be an engagement level of .75, meaning that, after 6 months in the program, clients will be engaged in ¾ of needed services.

Learning Goal 2. On-site housing *– Does on-site housing facilitate client engagement?*
The process (independent) variable for this learning goal is:

- Housing status – with possible categories being homeless, housed on-site at Everhart Village, temporary housing off-site, and long-term housing off-site.

The outcome (dependent) variable for this learning goal is:

- Client engagement in needed services.

Measures for the above process and outcome variables are shown in Table 4 below.

TABLE 4. VARIABLES AND PERFORMANCE MEASURES

Goal	Interventions	Measures of Program Processes	Performance Measures (Outcomes)
SHORT-TERM OUTCOME: Client engagement in needed services	On-site housing at Everhart Village	Check-box for housing status: homeless, housed on-site at Everhart Village, temporary housing off-site, and long-term housing off-site	# of engaged services per client / # of needed services per client

Project monitoring for Learning Goal Number 2.
REST will monitor the housing status of REST clients on a monthly basis. REST staff will use this data to help them keep track of their efforts to get clients off the streets and into temporary and permanent housing.

Evaluation of Learning Goal Number 2.
Quality Management will run comparison of means tests, or analysis of variance, to monitor the engagement rates of clients in each housing category. It is expected that stable housing status will facilitate client engagement in needed services.

Learning Goal 3. Comprehensive *- Is the overall REST approach of intensive outreach, coordinated care, and onsite housing, effective for engaging the target population in services?*

The process (independent) variables for this learning goal combine those from Learning Goals 1 and 2:

- Intensive outreach services;
- Client engagement in intensive outreach services;
- Client enrollment in needed services;
- Housing status – categories are homeless, housed off-site, and housed on-site at Everhart Village.

The outcome (dependent) variables for this learning goal are:

- Client engagement in needed services.

Measures for the above process and outcome variables are shown in Table 5 below.

TABLE 5. VARIABLES AND PERFORMANCE MEASURES

Goal	Interventions	Measures of Program Processes	Performance Measures (Outcomes)
SHORT-TERM OUTCOME: Client engagement in needed services	1. Intensive outreach services; 2. Client engagement in intensive outreach services; 3. Client enrollment in needed services. 4. On-site housing at Everhart Village	# of outreach attempts per client (per week) # of client connections per client (per week) # of enrolled services per client / # of needed services per client Check-box for housing status: homeless, housed on-site at Everhart Village, temporary housing off-site, and long-term housing off-site	# of engaged services per client / # of needed services per client

Ongoing Monitoring
The ongoing learning for this component combines the analysis for learning goals 1 and 2.

Evaluation
The relative contribution of each project element can be tested with a regression equation of the following form: Engagement rate = housing status + outreach effort + outreach time + outreach effort x outreach time.

Learning Goal 4. Learning Practice *- Is continuous quality improvement a good system for improving program and clinical practices and thereby improving client engagement?*
The process (independent) variables for this learning goal are:
Number of meetings in which quantitative data on engagement is reviewed. The standard will be bi-weekly.
The number of changes/experiments undertaken in response to performance data.
The outcome variable for this learning goal is:

- The quality and importance of the changes/experiments made in response to performance data.

Significant changes can be tracked using pre and post implementation data. Quality Management will also hold focus groups with REST participants once a year to get qualitative input on how continuous quality improvement is working.

Learning Goal *5.* Reducing *Symptoms and functional Impairments* *- Will Butte County Department of Behavioral Health (DBH), be able to help the REST target population with mental health, substance use, and functional impairments?*
Clients will start out in REST, and, if engagement efforts are successful, they will become engaged in treatment in one DBH's SEARCH programs or DBH's Substance Use Program. Learning goal number 5 assesses the extent to which REST clients, can be successful in treatment once they become engaged in DBH mental health programs.

After REST has been operating for 12 months, create the following population groups:

- **REST** – Consisting of clients that started in REST 6-12 months ago;
- **SEARCH** – Consisting of clients that started in DBH's SEARCH program 6-12 months ago.

Compare the two groups with respect to

- Demographic data: age, sex, ethnicity

- Baseline mental health symptoms
- Baseline substance use symptoms
- Baseline functional impairments
- Number of weeks in MH and/or substance use treatment

Compare the treatment gains between the REST group and the SEARCH group for the following dimensions:
- Mental health symptom improvement;
- SUD symptom improvement;
- Improvement in functional impairments.

Statistical Analysis
Statistical analysis of Learning Goal #5:
- Comparison of means tests for the REST and SEARCH groups;
- Comparison of means tests with the data further disaggregated by housing status (homeless, housed off-site, and housed on-site at Everhart Village).

Interpretation of comparison of means tests
If the clients recruited into the Butte County system of care through REST have treatment gains comparable to clients in SEARCH (who have never been in REST), that will support the hypotheses that this difficult to treat client population can be effectively engaged and treated.

Once 100 clients have graduated from REST, there will be enough data points for multiple regression analysis. The following multiple regression equations should be tested:

MH change = REST + TM time + TM intensity + TM time x TM intensity
SUD change = REST + TM time + TM intensity + TM time x TM intensity
FI change = REST + TM time + TM intensity + TM time x TM intensity

Where,
MH change = change in mental health symptoms from intake to last assessment;
SUD change = change in substance use symptoms from intake to last assessment
FI change = change in functional impairments from intake to last assessment
REST = dummy variable; code 0 if never in REST; code 1 if in REST for at least 30 days.
TM time = number of weeks in treatment with REST + SEARCH + substance use
TM intensity = average number of sessions per month including REST + SEARCH + substance use.

Interpretation of multiple regression equations
If the coefficient for the dummy variable, REST, is statistically insignificant (or positive), for each of the above equations, that would be evidence in support of the hypothesis that this difficult to treat client population can be effectively engaged and treated. Repeat the statistical analysis every 6 months.

Learning Goal *6. Changing lives* - *Will Butte County Department of Behavioral Health (DBH), be able to help the REST target population to obtain stable long-term housing, reduce its utilization of crisis services and hospitalizations, lower arrests, and raise employment?*
After REST has been operating for 12 months, create the following population groups:
- REST – Consisting of clients that started in REST 6-12 months ago;
- SEARCH – Consisting of clients that started in DBH's SEARCH program 6-12 months ago.

Compare the two groups with respect to
- Baseline housing status

- Baseline utilization of crisis services and hospitalizations
- Baseline arrests
- Baseline employment rates

This comparison will help Quality Management to make sense of the results. If REST clients do not have as much improvement in outcomes, but their baseline rates are more severe, then those baseline rates might provide clues on how best to serve this population. If baseline levels are comparable, and both groups have strong gains, that increases our confidence in attributing the gains to the REST program. If both groups have strong gains, but the baseline levels are less severe for the REST group, the gains can be explained by the lower severity and not as much by program efficacy.

Quality Management will compare the gains in ultimate outcomes between the REST group and the SEARCH group for improvements in the following areas:

- housing status
- utilization of crisis services and hospitalizations
- arrests
- employment rates.

Statistical analysis of Learning Goal #6:

- Comparison of means tests for the REST and SEARCH groups;
- Comparison of means tests with the data further disaggregated by housing status.

Interpretation of comparison of means tests

If the clients recruited into the Butte County system of care through REST have treatment gains comparable to clients in SEARCH (who have never been in REST), that will support the hypotheses that this difficult to treat client population can be effectively engaged and treated.

Multiple regression test

The following multiple regression equations would test the impact of REST status (REST graduate: yes/no), on ultimate outcomes, controlling for improvements in mental health, substance use, and functional impairment:

Housing status =	REST + MH + SUD + FUNC
Crisis events =	REST + MH + SUD + FUNC
Hospitalizations =	REST + MH + SUD + FUNC
Arrests =	REST + MH + SUD + FUNC
Employment =	REST + MH + SUD + FUNC

Where,
Housing status = change in housing status; logistic regression for categorical variable
Crisis events = change in the average number of crisis visits per month; pre – post comparison; pre intake average compared to average after REST/SEARCH intake date.
Hospitalizations = change in the average number of days hospitalized per year; pre – post comparison; pre-intake average compared to average after intake date.
Arrests = the difference between the average number of arrests in the last 6 months at intake and 6 month average during treatment.
REST = dummy variable; code 0 if never in REST; code 1 if in REST for at least 30 days.
MH = change in mental health symptoms from intake to last assessment;
SUD = change in substance use symptoms from intake to last assessment
FUNC = change in functional impairments from intake to last assessment

Interpretation of multiple regression equations

These regression equations would show the relative impact of REST and treatment gains on ultimate outcomes. If the coefficient for the dummy variable, REST, is statistically insignificant (or positive), for each of the above equations, that means that REST clients did as well as other client groups. That result would be further evidence in support of the hypothesis that this difficult to treat client population can be effectively engaged and treated. Quality Management will repeat the statistical analysis every 12 months.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

- The County will not be contracting Innovation services out.
- The County will be contracting with Chico Housing Action Team (CHAT) to provide property management and housing operations.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

2019 Summary of Community Input

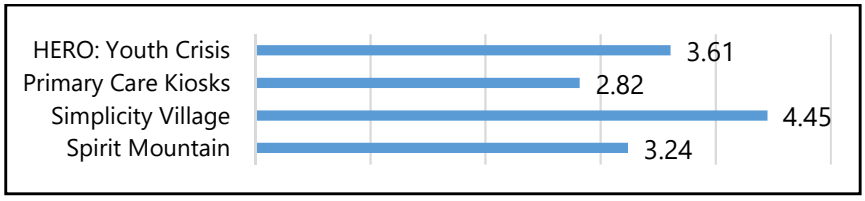
Butte County Behavioral Health (BCBH) began the community and stakeholder engagement process for the 2021-2023 Three Year Plan in early 2019. Community Input meetings were held with two different formats: five (5) large public meetings and ten (10) focus groups of MHSA funded programs. A total of **169 people** signed-in at the community meetings and focus groups. If individuals were not able to attend a meeting, they had the option to view a recording of the presentation on the MHSA website. Stakeholder feedback and community input resulted in **201 completed surveys**. The survey period was open from January 16th – March 1st, 2019.

2019 Survey Participant Affiliations*	***Totals***
Client/Consumer	40
Family of Client/Consumer	22
Education/School	21
Law Enforcement/Court/Probation	0
Native American Community	13
Hispanic/Latino Community	14
BCDBH Staff	30
Mental Health Service Provider (non-BCDBH staff)	8
Primary Care Providers/Clinics	7
Gay/Lesbian/Bisexual/Transgender Advocate	8
Asian/Pacific Islander Community	5
Transitional Age Youth (16-24 years of age)	6
Homeless Community	12
Cultural Competence Committee Member	1
Community Member	65
Decline to Answer	15
**Survey participants could select more than one answer.*	

During this Community Input Process, potential innovative concepts were presented to allow mental health stakeholders to identify which concept should be developed further. There were four innovative concepts introduced, and the public ranked the concepts on the most urgent need for MHSA funding. Administration and leadership utilized the results of this survey to allocate resources to develop the concepts further into future Innovation Projects.

Results

The feedback overwhelming indicated support for the project labeled "'Simplicity Village," which we now know today as Everhart Village.



Respondents could select between 0-5 as an overall score of the concept.

Simplicity Village Notable Community Comments

The following comments provided the basis or launch point for the proposed program in this document:

- "integrate alcohol and drug education and treatment into the process if it is needed"
- "Make WRAP mandatory participation for residence. Can't mandate treatment but maybe this group."
- "Ensure that integrated services are available ie: psychiatrists. Are behavioral Health psychiatrists going to assist by working with residents?"
- "I like the idea of involving social services in this concept. I hope that half way through the beneficiaries stay, each patient would have a social services representative assigned to meeting and working with them on post-departure social services needs so that everything is in place when they're discharged."
- "funding, screening the residents to effectively make a difference to those that really will participate vs ones that will use this opportunity as a handout to do nothing but get high and drain resources. Community resistance; NIMBY aka Not In My Back Yard"
- "Mental health begins with a stable living environment. Simplicity Village is the only proposal that offers a near-term housing alternative. It will enable residents to begin the healing process in a new and unique total immersion community."
- "I think the homeless mentally ill should be required to do some recovery work as in group therapy and individual counseling BEFORE they receive housing. In fact, I think it should be required in order to qualify for Simplicity Village. If there is no change, they will not be able to handle the housing and will take bad habits into the village."
- "I hope there is a trauma informed approach. Many people who are homeless have experienced trauma."
- "This type of project has proven very successful in other areas, not only for the residents but for the entire community. We would all benefit from the Simplicity Village."

2020 Summary of Community Input

The Department used community input from 2019 to design the vision for the Three-Year Plan, with the intention to share this vision with community members and stakeholders for an additional layer of input. In early 2020, a brief survey was, again, developed to solicit feedback and to collect demographics of the participants, to ensure that diverse perspectives were included in the process. Two community meetings and one staff stakeholder meeting took place, in-person, before the effects of the COVID-19 pandemic reached California.

In March 2020, the previously established community input meetings and the staff stakeholders' meetings were suspended due to illness precaution measures, and then transferred to a virtual platform. Three staff stakeholder meetings and six community input meetings, which included the Quality Improvement Committee and the Behavioral Health Board regular meetings, were facilitated virtually to gather input on the Three-Year Vision.

While not ideal, the virtual community input meetings were considered successful with **116 completed surveys**. The Department found that virtual community meetings overcame some barriers (lack of transportation, childcare) to participation and will utilize this method in the future.

2020 Survey Participant Affiliations*	*Totals*
Advocate	38
Children and Family Services	18
Client/Consumer/Recovery Community	17
Community Based/Non-Profit	42
Community Social Services	11
County BH Department Staff	48
Family Member of a Consumer	18
Foster Care	3
Health Care Provider/Worker	10
Homeless	15
K-12 Education Provider	5
Law Enforcement	1
MHSA Steering Committee	3
Other	14
Senior Services	3
Substance Use Disorder Services	7
Veteran Services	1
Declined to Answer	2

**Survey participants could select more than one answer.*

Results

The local community continued to support housing and homelessness initiatives for the MHSA. The community and stakeholder participation indicated support for the Simplicity/Everhart project through the frequent mention of affordable housing and peer specialist support. Themes included in the Community Input that support the implementation and design of the concept are as follows:

- *Housing*
  - Affordable was mentioned 13 times, house or housing was mentioned 43 times
  - Housing being closely linked to mental health and recovery and wellness
  - Increase housing that also provides supportive services onsite
- *Innovation*
  - Revisiting Innovation programs once COVID-19 is over
  - Supporting low income housing projects (i.e. Simplicity Village)
- *Laura's Law/Assisted Outpatient Treatment*
  - Support and opposition for the implementation of
- *Peer Workforce*
  - Increasing and maintaining the Peer Workforce, especially now with potential budget restraints
  - Training and education for peers
  - "Peer" was mentioned 23 times

2021 Summary of Community Input

BCBH utilized input received from the MHSA Steering Committee to guide the community input process for 2021, incorporating social distancing guidelines. An Introduction to MHSA video was created, in English and Spanish, and placed on the Behavioral Health website as a tool to provide education to the community and stakeholders throughout the year and not just during the Community Input process. The video presentation explained the MHSA, local program specifics by its funding component and how to engage in community program planning. There were six virtual community meetings scheduled, and the video and the survey was shared at the Behavioral Health Advisory Board, Cultural Competency Committee, and Quality Improvement Committee. Staff stakeholder specific sessions were also planned so the department could gain valuable insight from the in-house provider perspective regarding their experience with: unmet mental health needs in the community; barriers to treatment; prioritization of MHSA initiatives; and, the development of future Innovation projects. Stakeholder feedback and community input resulted in **261 completed surveys**.

Results

When the community was asked about what they felt were issues or barriers that make it challenging for consumers and their families to receive mental health services, the top issues or barriers were:

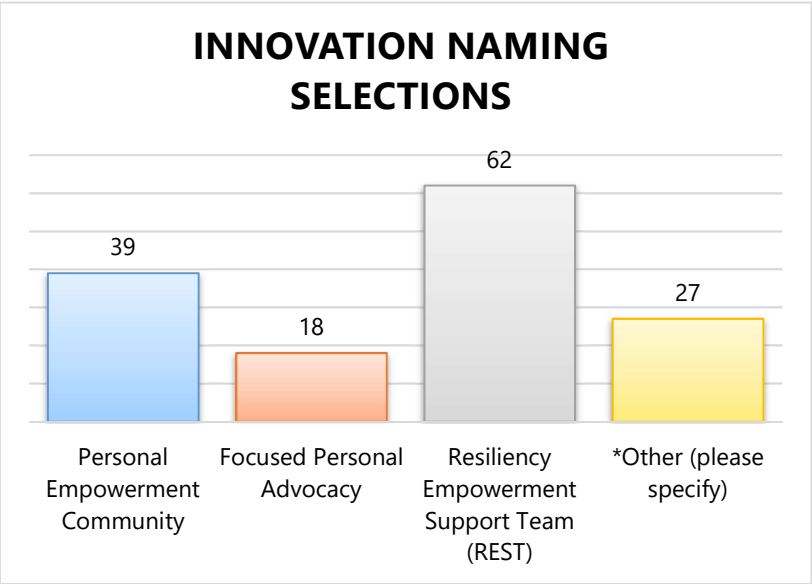
- Lack of knowledge about programs and services;
- Lack of transportation to appointments;
- Stigma around mental illness in your community,
- Concerns about costs; and,
- Unsupportive Family / Family Conflict

The most common mentioned theme throughout the survey responses this year was an overwhelming amount of people who feel that housing and affordable permanent housing in Butte County and homelessness in general are the main issues the County faces.

At the end of the Community Input feedback survey, community members and stakeholders were asked if they would like to provide input on a potential MHSA Innovation project. If the respondent answered yes, the survey would take them to the next portion of the survey where they could read the *Everhart Village Vision* narrative. **142 survey respondents stated they would like to provide input on the Innovation.**

2021 Survey Participant Affiliations*	***Totals***
Advocate	101
Children and Family Services	14
Client/Consumer/Recovery Community	40
Community Based/Non-Profit	70
Community Social Services	30
County BH Department Staff	41
Cultural/Diverse Background	20
Family Member of a Consumer	37
Foster Care	12
Health Care Provider/Worker	29
Homeless	25
K-12 Education Provider	12
Law Enforcement	5
LGBTQI+ Community	23
Racial/Ethnic Background	14
Senior Services	22
Substance Use Disorder Services	10
Veteran Services	9
None	25
Decline to Answer	4
Other	26

**Survey participants were allowed to select more than one answer.*



Since Everhart Village is just one piece of the overall Innovation Vision, the Department was provided the top three names for the Innovation project by a separate stakeholder group (see "Stakeholders of Butte County", below). These three naming conventions were placed on the survey so the community could select an appropriate name for Innovation portion of the project or provide an option of their own. There were 119 selections for one of the provided names and 27 entries for "Other". The results of this survey informed the name for this Innovation project; *Resiliency Empowerment Support Team (REST) at Everhart Village*

There was an overwhelming response of "permanent, affordable housing" when asked what could be added to strengthen the overall concept of this potential Innovation. This was the same response received when asked about barriers and concerns. The community felt that the lack of permanent, affordable housing could become an issue at the end of the six month stay. Some of the other community concerns were funding and neighborhood opposition.

Stakeholders of Butte County

In October of 2019, two Innovative concepts were submitted from a consumer stakeholder group to the department and the Behavioral Health Advisory Board. Those two concepts were titled Mobile Arts Outreach and Whole Person Care. Components from both of those concepts were infused into the REST Project, including the emphasis on Peer Support Specialists being the main source of care coordination, and imbedding the therapeutic art activities into the proposed computer lab. This Stakeholder group also provided the three possible names for the Innovation project, that the community was able to vote for during the 2021 Community Input process.

Stakeholders of Butte County

Mission Statement

We, as people who have a stake and a role in mental wellness in Butte County, prioritize individual and community whole health, wellness, housing, and basic needs through advocacy and accountability in the mental health system.

In 2021, the group re-branded Community Whole Health Alliance (CWHA) and engaged in ten-year strategic planning. CWHA is now a 25-plus member grassroots, peer-led organization preparing for non-profit incorporation. Their purpose is advocacy and system change in mental health services to build recovery support for persons affected by mental illness, substance use, stigma, isolation, and trauma with an emphasis on rural Butte County. CWHA will develop Peer Support Specialists training that would satisfy SB803 Peer Certification requirements: for areas of specialization for homelessness, crisis response, and forensic peer support; specific to rural Butte County.

The REST Innovation plan includes the Whole Person Care Peer Support Specialists as part of an on-site mental health support team for unhoused persons in 2022. CWHA continues to contribute to the project as well as advancing Peer Support as a mental health specialty practice. CWHA was instrumental in the county raising Peer wages and adding the first full-time positions for Peer Support Specialists.

Everhart Workgroup

Quarterly workgroup meetings were established beginning in October 2019. Stakeholders included members from CHAT (Chico Housing Action Team) and BCBH staff from various areas in the department. This workgroup transitioned to meeting monthly after Butte County Board of approved an agreement in September 2020 between BCBH and CHAT providing Homeless Mentally Ill Offender Treatment (HMIOT) funding in the amount of $175,000 to begin the development of the community.

REST Workgroup

A workgroup consisting of administrative and clinical BCBH staff convened in March 2021 to begin drafting the REST Project Plan Template (current document). This group met on a weekly basis to work through the narrative and program operations. This group reviewed all feedback submitted during the 30-day public comment period and worked together to incorporate the feedback into this proposal (see below).

MHSA Steering Committee

The MHSA Steering Committee began meeting in October 2019. The Committee members were brought together by thoughtful consideration and selection from an ad hoc committee from the Behavioral Health Advisory Board, who reviewed the applicants and recommended appointees based off of stakeholder diversity.

This Committee is made up of stakeholders from agencies, community members, and consumers/family members to represent the community, working in a collaborative and advisory capacity to the Executive Team as it specifically relates to MHSA funded programs, initiatives, and services.

This Steering Committee formed an Innovation Subcommittee, which was kept apprised of activities related to the design of REST on a bi-monthly basis.

Butte County Behavioral Health Advisory Board

At the May 19, 2021 Behavioral Health Advisory Board meeting, an informational presentation on Laura's Law was provided to the Board, which included concepts related to REST. Following this presentation was lengthy discussion and the Board voted unanimously to recommend the REST program to the Board of Supervisors as an alternative to Laura's Law.

Butte County Board of Supervisors

At the June 08, 2021 Butte County Board of Supervisor meeting, the Board adopting a resolution to opt out of Assisted Outpatient Treatment (Laura's Law), and affirmed their support that the REST project would be an appropriate alternative for Butte County.

"The Department of Behavioral Health recommends opting out of implementing Laura's Law due to the availability of ongoing funding. Rather, the Department will be applying for Mental Health Services Act Innovation funding seeking to establish an outreach and engagement program that incorporates many components of an AOT program entitled Resiliency, Empowerment Support Team."-Board of Supervisor Agenda

EQRO

On August 19, 2021, The External Quality Review Organization conducted their annual review of the Butte County Mental Health Plan. BCBH MHSA Coordinator provided a presentation to the EQRO to solicit input and feedback. Their feedback was favorable and supportive, and they recommended that BCBH include safety considerations in the proposed program.

30-Day Public Comment Period

The REST Proposal was posted for 30-day public comment period on December 20, 2021. A public hearing was held for the project on January 19, 2022 at the Behavioral Health Advisory Board (BHAB) Meeting. During the 30-day public comment, 35 submissions were received via email. The majority of this feedback was in support of the project, and there was robust and meaningful input submitted for the Department's consideration. The BHAB approved the proposal, citing the overwhelming public support with the condition that the suggested changes to the project be thoughtfully considered by the Department. The following is a brief summary of suggestions, the Department's response and/or the changes made to the proposal. It should be noted that there are also many factors of the input that will assist with future program planning.

30-Day Public Comment	Adaptation and/or response to feedback
Peers FTE should equal Counselors FTE to decrease stigma and balance the power dynamic among co-workers	One counselor will utilize lived experience to provide support and care coordination in keeping with the core values, ethics, and best practices of peer service. This counselor will achieve statewide peer certification and will keep an emphasis on the critical role of peers in the delivery of core services. The creation of this Peer Counselor hybrid position will provide capacity building for the peer support role in the department by establishing an enhanced career ladder for peers. This innovation will provide the pilot to establish best practices for peers at varying levels of the organization.

30-Day Public Comment	Adaptation and/or response to feedback
	The proposed staffing change would not affect the budget, and would update the staffing ratio to 3FTE Counselors, 1 FTE Counselor/Peer, 2FTE Peers and 2 Extra Help peers for a more balanced approach.
Restructure language to reflect the values off peer support more accurately	Language has been updated to better reflect Peer Support Specialist roles and purpose in various areas of the document.
Providing clearer definition of outreach	BCBH acknowledges that it would be helpful to develop a universal definition of outreach which explains that "meeting people where they are at" relates to geographically and one's state of mind.
Peer Career Ladder	The creation of a Peer Counselor hybrid position will provide capacity building for the peer support role in the department by establishing an enhanced career ladder for peers. This innovation will provide the pilot to establish best practices for peers at varying levels of the organization.
Peer Support Evaluation Outcomes	REST will involve front-line staff (including Peer Support Specialists), and beneficiaries, in defining other outcomes and outcome measures. The types of outcomes and outcome measures that will be developed through a participatory evaluation process cannot be specified in advance, but could include stigma reduction and improvement of mental health systems.

Training, Mentoring and Team Building	BCBH acknowledges the following community input; "As organizational capacity matures and develops for REST, SEARCH, and Everhart Village, and BCBH generally, Peer capacity building likewise needs to develop in keeping with the emphasis on the critical role of peers in the work of recovery and resilience support, and delivery of core services. "
	
	Other considerations from community input that the Department will incorporate to the building of the REST program:
	• Peer Certification and Specialization
	  ○ Continuing education
	  ○ Elective certification in selected SB 803 Specialization and appropriate supervision
	  ○ Ensure collective and individual growth in expanding peer roles over time
	• Training, Mentoring and Supervision
	  ○ Acquiring service-specific techniques and skills vs Support and guidance of a trusted veteran
	  ○ Program planning and performance evaluation vs Support and guidance from trusted veteran
	  ○ Pairing clinical and peer staff members; Two-way mentoring
	  ○ Pairing newer peers with experienced peer
	• Team Development and Synergy
	  ○ Hiring and incorporating staff vs melding group cohesiveness and commitment
	  ○ Amicable group interactions vs synergistic values-based processes
	  ○ Social events vs Structured interactive group experiences resulting in workforce synergy
	  ○ Synergy enhances REST, SEARCH, and Everhart Village personnel alike
	  ○ Synergy makes possible an outcome that is greater than the sum of its parts

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A. *Community Collaboration:*

As demonstrated above, this project has been developed after comprehensive vetting in the community and with mental health stakeholders. Input was gathered over three years and incorporated into this plan. Community input and partnership with the community are core elements of our innovation project.

In addition to partnering with community members this project partners with a locally based non-profit organization (CHAT) and the Homelessness Division of the Butte County Department of Employment.

B. *Cultural Competency*

BCBH staff are trained to incorporate culturally aware practices to ensure clients' cultural identities, needs, and values are respected at all times. In addition to currently available translation services, it is the intention of the department to demonstrate our county's commitment to serving culturally diverse communities and individuals by recruiting bilingual and multi-cultural staff. To develop an internal departmental culture of awareness, the Department relies on the expertise and advice of the Ethnic, Diversity, and Inclusion Committee facilitated by the Clinical Training Coordinator.

Lesbian, Gay, Bisexual, Transgender, and Queer/questioning (LGBTQ+) individuals are part of every community, and are present in every racial, ethnic, socioeconomic, and geographical group. Research suggests that LGBTQ+ individuals face health disparities[72] linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBTQ+ persons have been associated with causing high rates of psychiatric disorders, substance use and suicide. Additionally, this population encounters a higher rated of homelessness and trauma; Transgender and gender non-conforming adults who experience homelessness encounter several additional challenges in the homelessness system, particularly in regard to gender-affirming support and basic safety. Transgender individuals also face challenges with other residents at shelters, making them more reluctant to move indoors.

BCBH acknowledges the disparities mentioned above, and anticipates interacting with this population at a high rate due to the aforementioned circumstances. The REST staff will seek out and receive comprehensive training on appropriate supports and interventions for LGBTQ+ individuals. BCBH currently partners with the local Stonewall Alliance Center, which receives MHSA Prevention and Early Intervention (PEI) funding to provide Stigma and Discrimination Reduction services. Stonewall tailors and designs their training to address the audience desiring training. They specify training to provide to mental health, social service, medical and peer support providers and take into account any specific needs at that current time. They are also available to provide peer support and advocacy assistance specific to the needs of LGBTQ+ clients.

C. *Client-Driven*

This proposal adopts the 'whatever-it-takes' philosophy to meet clients where they are at and to provide non-traditional services and supports to develop rapport and build engagement with mental health services. This approach will promote engagement in services by prioritizing client-identified needs and adapting to them. Once enrolled in REST, services are tailored to the specific needs of the individual; goals are designed in collaboration with the individual to ensure client voice and choice is present. Each client or potential client will be served with flexibility, incorporating unique interventions and services.

Wellness and Recovery Action Plan (WRAP) is one of the models that is being incorporated into this unique setting. WRAP is a personalized wellness and recovery system born out of, and rooted in, the principle of self-determination.[73] This model ensures that clients are leading the path to their own wellness. By definition, the person is the one who develops their goals; however, the person may choose to have supporters, including health care professionals, family members to help them create their plan, but the individual remains in control of the process.

D. Family-Driven

This project will only serve adults; therefore, this general standard of MHSA does not relate. However, our project can directly impact and improve family situations by accepting referrals from family members who need professional help to support their loved ones who suffer from SMI. BCBH recognizes the stress and pain of having a loved one with untreated serious mental health symptoms. For the first time in Butte County, family members will be able to refer loved ones to receive outreach services. Staff will work collaboratively with families and loved ones to gather valuable information to assist in the outreach and engagement process. The Department also recognizes the importance of working with the family or significant others throughout the treatment process, pending client approval.

E. Wellness, Recovery, and Resilience-Focused

All services provided to a community member will be recovery and wellness oriented and will consider all aspects of the person's well-being (mental health, physical health, substance use issues, vocational needs etc.). Wellness and Recovery Action Plan (WRAP) is one of the models that is being incorporated into this unique setting. WRAP is a personalized wellness and recovery system born out of, and rooted in, the principle of self-determination.[74] This model ensures that clients are leading the path to their own wellness. By definition, the person is the one who develops their goals; however, the person may choose to have supporters, including health care professionals, family members to help them create their plan, but the individual remains in control of the process.

F. Integrated Service Experience for Clients and Families

Integrated services are the driving force of this Innovative project. This project proposes to overcome barriers to treatment and lack of integrated services is a barrier. Additionally, a large component of this project is to provide robust peer support to clients to help navigate integrated services. Peers will coordinate physical health, behavioral health, social services, substance use, legal, housing, transportation, medication, youth intervention, senior care, and other services for at risk clients who use multiple services.

All services provided to a community member will be recovery and wellness oriented and will consider all aspects of the person's well-being (mental health, physical health, substance use issues, vocational needs etc.).

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

In addition to the already established robust Community Input Process, BCBH will convene an evaluation work group composed of diverse community members and department staff that review the evaluation data and provide feedback on a quarterly basis. As the Program Evaluation is completed on a quarterly basis, BCBH will provide the Evaluation to the leadership team, program staff, and the Butte County MHSA Steering Committee for review and input.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

BCBH plans on using what is learned in this project to make any improvements needed for long-term sustainability. There will be CalAim funding that will become available in the future that requires a strong partnership with the Managed Health plans, Health clinics, and Social services. This Innovation project is very important to the Department as the hope is that this project will become more effective than Laura's Law as it is more preventive and does not focus on the rigid requirements that Laura's Law requires to qualify for services. The goal is to use this Innovation project to help launch the start-up services needed for longer sustainability as BCBH will require some time to create a cultural shift for our staff on how services are provided to hard to reach populations that do not seek out services on their own.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.
The Goal of the Department is to primarily offer services to those with SMI for this project. Continuity of care will be ensured through offering up to 6 months of active intensive outreach until clients link into SEARCH FSP services, offering optional housing for those with SMI that are homeless in a centralized treatment hub that ensures our treatment teams will be able to locate clients much easier. IOT will connect all clients to whole person care as needed and offer field-based services to ensure clients do not miss appointments. The IOT team will work closely to ensure continuity of care and care coordination for all clients referred.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A. *How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?*

Media Presence: BCBH employs a Public Information Officer (PIO), also the acting MHSA Coordinator, who is responsible for issuing press releases, answering queries from the media and arranging interviews with BCBH leadership or content experts. Part of a PIO's ongoing job is to establish good working relationships with the media and the public and to maintain those relationships by answering queries promptly, arranging interviews or speakers when requested and being a familiar and involved presence at community events. If this program were to be funded, there would be a press release supplied to local media to promote and educate the community.

Social Media: The MHSA Coordinator/PIO will launch a social media presence for BCBH, which will be used to provide updates on REST initiatives and outcomes. This social media presence will also allow for community members and stakeholders to gain an understanding of the referral process for REST.

Website: The MHSA Coordinator/PIO is responsible for maintaining the BCBH website, and information related to this project and how to refer individuals will be available on this website.

Collaborative Partners: In addition to the external communications plan, the county must effectively communicate internally while still staying within the parameters set by the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state privacy laws. The success of a county triage program is contingent upon ongoing communication between collaborative partners and county programs. Intra-county

communication is key to breaking down the silos that exist within some county programs. Triage personnel must stay apprised of other triage programs as well as public and private non-county service options and resources.

Business Cards/Brochures: REST staff will carry identifying business cards to help facilitate community engagement. In addition, these business cards will be distributed to social service access points, including, but not limited to: outpatient mental health clinics; crisis service locations; community-based organizations; local Federally Qualified Health Centers; and housing resources.

TIMELINE

Start Date: July 1, 2022
End Date: June 30, 2027

FY22/23 *(7/1/2022-6/30/2023)*	**FY23/24** *(7/1/2023-6/30/2024)*	**FY24/25** *(7/1/2024-6/30/2025)*	**FY25/26** *(7/1/2025-6/30/2026)*	**FY26/27** *(7/1/2026-60/30/2027)*
Year 1	Year 2	Year 3	Year 4	Year 5

A. *Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.*

There will be one team that covers the entire County. This team will be located in Chico, but will provide outreach to any location in Butte county and will be primarily field based. The IOT will have 1Supervisor, 1 Clinician, 4 counselors, 2 full-time peers and, in addition, access to extra help peers, and a nurse and psychiatrist on an as needed basis. The estimate of individuals served is based on the following assumptions:
There will be one team that covers the entire County. This team will be located in Chico, but will provide outreach to any location in Butte county and will be primarily field based. The IOT will have 1 Supervisor, 1 Clinician, 3 counselors, 1 counselor peer specialist, 2 full-time peers and, in addition, access to extra help peers, and a nurse and psychiatrist on an as needed basis.

The estimate of individuals served is based on the following assumptions:

- The team will have a caseload of 20 clients for 6 months;
- 20 clients every 6 months x 2 = 40 clients every 12 months;
- Assume 4 clients per year dropping out, freeing up an additional 4 slots;
- 40 clients + 4 replacement clients = 44 clients per year.

This caseload was deemed appropriate when considering the 3-month IOT pilot that the Department implemented in early 2021. Therefore, it's anticipated that IOT will be able to accept 44 referrals from the community, per year. It is estimated that 22 of those referrals will enter into BCBH services.

FY22/23	***Q1 (July-September)***	***Q2 (October-December)***	***Q3 (January-March)***	***Q4 (April- June)***
Staffing	Supervisor 1FTE Clinician 2 FTE Counselors 2FTE Peers	Ongoing recruitment for vacancies	Program will be fully staffed	
Referral education and outreach		2	4	6
IOT Participants	0	5	4	7

Everhart Guests		2	2	2
Facilities/Capital	Purchase vehicles, office supplies, furniture, technology, lease space			
Training			Schedule targeted trainings	Offer targeted trainings
Evaluation	Finalize forms for tracking performance data; Train staff on inputting performance data; Monitor staff completion of data gathering.	Monitor staff completion of data gathering. Train staff in how to use outcome data to drive continuous improvement; Provide quarterly performance data to REST Teams.	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams

FY23/24	***Q1***	***Q2***	***Q3***	***Q4***
Referral education and outreach	4	4	3	3
IOT Participants	11	11	11	11
Everhart Guests	3	3	3	3
Facilities/Capital				
Training	ongoing	ongoing	ongoing	Annual renewal training
Evaluation	Monitor staff completion of data gathering. Analyze annual statistical data. Complete year 1 evaluation report.	Monitor staff completion of data gathering. Annual staff training on how to use outcome data to drive continuous improvement; Provide quarterly performance data to REST Teams.	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams.	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams.

FY24/25	***Q1***	***Q2***	***Q3***	***Q4***
Referral education and outreach	3	3	3	3
IOT Participants	11	11	11	11
Everhart Guests	3	3	3	3
Facilities/Capital				
Training	ongoing	ongoing	ongoing	Annual renewal training
Evaluation	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams. Analyze annual statistical data. Complete year 2 evaluation report.	Monitor staff completion of data gathering. Annual staff training on how to use outcome data to drive continuous improvement; Provide quarterly performance data to REST Teams.	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams.	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams.

FY25/26	***Q1***	***Q2***	***Q3***	***Q4***
Referral education and outreach	3	2	1	1
IOT Participants	11	11	11	11
Everhart Guests	3	3	3	3
Facilities/Capital				
Training	ongoing	ongoing	ongoing	Annual renewal training
Evaluation	Monitor staff completion of data gathering. Analyze annual statistical data. Complete year 3 evaluation report.	Monitor staff completion of data gathering. Annual staff training on how to use outcome data to drive continuous improvement;	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams.

		Provide quarterly performance data to REST Teams		

FY26/27	***Q1***	***Q2***	***Q3***	***Q4***
Referral education and outreach	1	1	1	
IOT Participants	11	11	11	
Everhart Guests	3	3	3	
Facilities/Capital				
Training	ongoing	ongoing	ongoing	
Evaluation	Monitor staff completion of data gathering. Analyze annual statistical data. Complete year 4 evaluation report.	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams	Monitor staff completion of data gathering. Provide quarterly performance data to REST Teams	Complete comprehensive multi-year evaluation report. Determine continuation of program.

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A. *BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)*
B. *BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)*
C. *BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)*

TOTAL PERSONNEL BCBH is proposing to recruit 1.0 FTE Supervisor, 1.0 FTE Clinician, 3.0 FTE Behavioral Health Counselors, 1.0 FTE Peer Support Counselor, 2.0 FTE Peer Support Specialists, two .5 FTE extra help Peer support specialists, .5 FTE Medical Records Technician, .5 FTE Administrative Analyst, .25 FTE Psychiatrist and 1.0 FTE Nurse to support this new innovation project. For more information related to the duties and responsibilities of staff, please see *Proposed Project*.	**$3,298,966**
TOTAL OPERATING Operating cost identified in the budget include the building lease for the computer lab, which will be located in the same building as Chico Adult Services (including the SEARCH office), Substance Use Disorder Treatment, and Crisis Services. The flex funds will be used as incentives to engage clients and relationship building (i.e., toiletries, food, blankets). Emergency housing funds are for those REST participants who are located in other areas of the County other than Chico. These funds may be used for hotels in their area of residence	**$183,078**
TOTAL NON-RECURRING COSTS For program implementation, the budget includes costs for computers for staff, for the client computer lab and 2 vehicles for the outreach and engagement personnel to travel in the field.	**$133,000**
TOTAL CONSULTANT COSTS/CONTRACTS Contracted .25 Psychiatrist and 1.0 FTE nurse will be a part of the REST Service Delivery Team., Consultants are anticipated to utilized for specialized training needs.	**$1,236,300**
TOTAL OTHER EXPENDITURES This category includes expenditures such as medical malpractice insurance, County A87 support expenditures, information technology support, human resources, etc.	**$850,873**
TOTAL PROGRAM COSTS As detailed above	**$5,702,217**
TOTAL ADMINISTRATION COSTS Administrative costs identified in the budget include supplies and administrative personnel necessary to support financial accountability, reporting, tracking grant funds, and records retention.	**$507,639**
TOTAL EVALUATION COSTS Includes a .5 FTE Analyst to implement the evaluation of the project.	**$188,744**
GRAND TOTAL	**$6,398,600**

BCBH anticipates that the Department of Health Care Services (DHCS) CalAIM initiatives related to enhanced care management (proposed to be fully implemented in 2022) will support ongoing funding for these positions, along with the increased capacity in Medi-Cal due to DHCS redefining medical necessity to allow for outreach services, and additional enhanced care management strategies will support funding these positions.

Reversion Considerations

Butte County anticipates using funds that are at risk of reverting back to the DHCS if they are not encumbered to the REST Project. The breakdown of Fiscal Years of funds that are subject to reversion include:

- $136,427, - to revert 6/30/2022 (estimated remainder of BCOE Care Project encumbered funds pending ARER/Cost Report completion)
- $520,319 – FY 19/20 Funds – reverts 6/30/22
- $773,775 – FY 20/21 Funds – reverts 6/30/23

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
1.	Salaries						
2.	Direct Costs	**$733,102**	**$733,102**	**$733,102**	**$733,102**	**$366,558**	**$3,298,966**
3.	Indirect Costs						
4.	**Total Personnel Costs**	**$733,102**	**$733,102**	**$733,102**	**$733,102**	**$366,558**	**$3,298,966**
	OPERATING COSTS*						
5.	Direct Costs	**$39,078**	**$36,000**	**$36,000**	**$36,000**	**$36,000**	**$183,078**
6.	Indirect Costs						
7.	**Total Operating Costs**	**$39,078**	**$36,000**	**$36,000**	**$36,000**	**$36,000**	**$183,078**
	NON-RECURRING COSTS (equipment, technology)						
8.	Computer Equipment	**$45,000**					**$45,000**
9.	Vehicles	**$88,000**					**$88,000**
10.	**Total non-recurring costs**	**$133,000**					**$133,000**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs	**$247,260**	**$247,260**	**$247,260**	**$247,260**	**$247,260**	**$1,236,300**
12.	Indirect Costs						
13.	**Total Consultant Costs**	**$247,260**	**$247,260**	**$247,260**	**$247,260**	**$247,260**	**$1,236,300**
	OTHER EXPENDITURES (please explain in budget narrative)						
14.	Indirect	**$130,904**	**$196,355**	**$196,355**	**$196,355**	**$130,904**	**$916,324**
15.							
16.	**Total Other Expenditures**	**$130,904**	**$196,355**	**$196,355**	**$196,355**	**$130,904**	**$916,324**
	BUDGET TOTALS						
	Personnel (total of line 1)						
	Direct Costs (add lines 2, 5, and 11 from above)	**$1,019,440**	**$1,016,362**	**$1,016,362**	**$1,016,362**	**$649,818**	**$4,718,344**
	Indirect Costs (add lines 3, 6, and 12 from above)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Non-recurring costs (total of line 10)	**$133,000**	**$0**	**$0**	**$0**	**$0**	**$133,000**
	Other Expenditures (total of line 16)	**$130,904**	**$196,355**	**$196,355**	**$196,355**	**$130,904**	**$850,873**
	TOTAL INNOVATION BUDGET	**$1,283,344**	**$1,212,717**	**$1,212,717**	**$1,212,717**	**$780,722**	**$5,702,217**
BUDGET CONTEXT – EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							

A.	Estimated total mental health expenditures <u>for administration</u> for the entire duration of this INN Project by FY & the following funding sources:	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
1.	Innovative MHSA Funds	$105,319	$112,675	$112,675	$112,675	$64,295	**$507,639**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Administration**	**$105,319**	**$112,675**	**$112,675**	**$112,675**	**$64,295**	**$507,639**
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
1.	Innovative MHSA Funds	**$41,943**	**$41,943**	**$41,943**	**$41,943**	**$20,972**	**$188,744**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Evaluation**	**$41,943**	**$41,943**	**$41,943**	**$41,943**	**$20,972**	**$188,744**
TOTALS:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
1.	Innovative MHSA Funds*	**$998,403**	**$664,039**	**$664,039**	**$664,039**	**$520,000**	**$3,510,520**
2.	Federal Financial Participation	**432,203**	**$703,296**	**$703,296**	**$703,296**	**$345,989**	**$2,888,080**
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding**						
6.	**Total Proposed Expenditures**	**$1,430.606**	**$1,367,335**	**$1,367,335**	**$1,367,335**	**$865,989**	**$6,398,600**

*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting**
**** If "other funding" is included, please explain within budget narrative.**

[1] https://www.who.int/mental_health/management/info_sheet.pdf
[2] https://www.census.gov/quickfacts/fact/table/US,CA,buttecountycalifornia/INC110218
[3] Kilbourne AM, Fullerton C, Dausey D, et al A framework for measuring quality and promoting accountability across silos: the case of mental disorders and co-occurring conditions BMJ Quality & Safety 2010;19:113-116.
[4] Mohler, Jane M. Collaboration Across Clinical Silos, Frontiers of Health Services Management: Summer 2013 - Volume 29 - Issue 4 - p 36-44.
[5]Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA;
[6] Hackman, J., & Wageman, R. (1995). Total quality management: Empirical, conceptual, and practical issues. *Administrative Science Quarterly*; Jun 1995; 40, 2: 309-342.
[7] Chinman, M., Hunter, S., Ebener, P. (2012). Employing continuous quality improvement in community-based substance abuse programs, *International Journal of Health Care Quality Assurance*; 25(7): 604–617.

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[10] Henderson, P., et al., (2020). Mental health practitioner experiences of engaging with service users in community mental health settings: A systematic review and thematic synthesis of qualitative evidence. p. 809.
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APPENDIX A. PROGRAM LOGIC MODEL AND PERFORMANCE MEASURES

REST PROGRAM LOGIC MODEL

TARGET POPULATION	ACTIVITIES INTERVENTIONS	DIRECT PRODUCTS	SHORT-TERM OUTCOMES	INTERMEDIATE OUTCOMES	ULTIMATE OUTCOMES
Meets criteria for Specialty Mental Health Services Mental health condition is deteriorating At risk of psychiatric hospitalization Homeless or at risk of homelessness Not engaged in outpatient mental health services	Screen potential clients Intensive outreach Services • Support • Referrals Innovative programming • Whole-person care • Peer Support Specialists • Continuous Quality Improvement	Client **engagement** in intensive outreach Client **enrollment** in • Mental health • Healthcare • Housing • Benefits • Employment and Training	Client **engagement** in essential services • Mental health • Medical • Housing • Employment/ training	Improvement in mental health symptoms Substance use down Improvement in functional impairments	Stable long-term housing outside the program Crisis evaluations down Psychiatric hospitalizations down Arrests down Stable employment

REST PROJECT ACTIVITIES, DATA, AND POSSIBLE MEASURES

ACTIVITIES / INTERVENTIONS	SOURCE OF DATA	EXAMPLES OF MEASURES
Screen potential program clients	REST project dbase in Access or Avatar EHR	No. of referrals received No. of clients opened by REST each month
Intensive Outreach Services	Progress Note in Avatar EHR –	No. of outreach attempts and contacts, per client, per week - Info note: for outreach attempt - Check box for "left message" - Progress note: for client contact

REST DIRECT PRODUCTS, DATA, AND POSSIBLE MEASURES

DIRECT PRODUCTS	SOURCE OF DATA	EXAMPLES OF MEASURES
Client engagement in Intensive Outreach	**Engagement –** the Service Engagement Scale (SES) (every 30 days); keep on spreadsheet or DBH Avatar	**Engagement –** the SES measures 4 dimensions of engagement: availability, collaboration, help seeking, and treatment adherence.

		Initial Engagement – when client has 2 or more connections with the intensive outreach team per week in first 30 days after being opened to REST. **Ongoing Engagement** – at least 2 or more connections with the intensive outreach team per week.
Client enrollment in needed services • Mental health • Substance Use • Medical • Housing • Employment/ training • Benefits	Progress note with check boxes for needed and enrolled services; answer the check boxes on the progress note form at least 1x per month, or more frequently if there is a change.	Check boxes showing needed and enrolled, for: - Mental Health - Substance Use - Medical - Housing - Employment/Training - Benefits Enrolled status converts to engaged after 30 days of meeting requirements. Overall engagement is given by the ratio of engaged to needed services; Please see details below.

ENROLLMENT TO ENGAGEMENT TRANSITION

Service	Needed	Enrolled
Mental Health	☐	☐
Healthcare	☐	☐
Temporary housing	☐	☐
Long-term housing	☐	☐
Employment/training	☐	☐
Benefits, e.g. Calfresh	☐	☐

Mental Health/Substance Use Treatment:

- **enrolled**: when have completed paperwork to be opened to that treatment episode
- **engaged**: when have two or more services within 30 days of being opened to a particular treatment episode
- **ongoing**: 2 services per month = engagement in MH or SUD

Healthcare:

- **enrolled**: when go to see medical provider, or established care with primary care
- **engaged**: if have medical issues and compliant with treatment for 30 days → engaged
- **ongoing**: if have medical issues and not compliant with treatment check "needed" and leave "enrolled" unchecked
- **ongoing**: if do not have medical issues and don't go; leave "needed" and "enrolled" unchecked

Temporary housing

- enrolled when get on a waiting list for temp housing; includes Everhart Village
- engaged when move into temp housing and meeting requirements to stay

Long-term housing
- enrolled when get on a waiting list for permanent housing
- engaged when move into permanent housing and meeting requirements to stay

Employment/training
- enrolled when start job or training program
- engaged when meet requirements of job or training program for 30 days
- ongoing: engaged if continue to meet requirements of job or training program

Benefits
- Enrolled when sign up for needed benefits
- Engaged 30 days after enrolling

REST DIRECT PRODUCTS, DATA, AND POSSIBLE MEASURES

DIRECT PRODUCTS	SOURCE OF DATA	EXAMPLES OF MEASURES
Continuous Quality Improvement	Short-form with • Follow-up from last meeting • New issues raised • Decisions made	Number of meetings in which quantitative data on engagement is reviewed Innovations and improved practices that emerge from team meetings

REST SHORT-TERM OUTCOMES, DATA, AND POSSIBLE MEASURES

SHORT-TERM OUTCOMES	SOURCE OF DATA	EXAMPLES OF MEASURES
Engagement in essential services: • Mental health • Medical health • Housing • Employment/ training • Benefits	Progress note with check boxes for needed and enrolled services; answer the check boxes on the progress note form at least 1x per month, or more frequently if there is a change.	Check boxes showing needed and enrolled, for: - Mental Health - Substance Use - Healthcare - Housing - Employment/Training - Benefits Enrolled status converts to engaged after 30 days of meeting requirements. Overall engagement is given by the ratio of engaged to needed services; See details above.

REST INTERMEDIATE OUTCOMES, DATA, LOCRI

INTERMEDIATE OUTCOMES	SOURCE OF DATA	EXAMPLES OF MEASURES
Improvement in mental health symptoms Substance use symptoms Improvement in functional impairments	Milestones of Recovery Scale (MORS) in Avatar; Administered at intake and every 6 months.	**Recovery Progress** Overall MORS score
Improvement in mental health symptoms Substance use symptoms Improvement in functional impairments	Adult Level of Care and Recovery Inventory (LOCRI) in Avatar; Administered at intake and every 6 months.	LOCRI items: **Mental Health** Current engagement in self-injurious behavior. Yes/no Current grave disability. Yes/no Current violent behavior. Yes/no 1. Suicidal/homicidal acuity 2. Psychotic symptom scale 4. Depression severity: mild – severe **Substance use** Active substance use -drugs -No. of days for each drug 17. substance use scale 18. need for detox services **Functioning and Support** 7. Self-care: no impairment – grave disability 8. Engagement with family 9. Ability to maintain employment/education 10. Ability to engage with social supports 11. Community involvement

REST ULTIMATE OUTCOMES, DATA, AND POSSIBLE MEASURES

ULTIMATE OUTCOMES	SOURCE OF DATA	EXAMPLES OF MEASURES
Stable long-term housing outside the program Stable income Stable employment Crisis evaluations down Psychiatric hospitalizations down	**Housing** Adult Level of Care and Recovery Inventory (LOCRI) in Avatar **Employment** Adult Level of Care and Recovery Inventory (LOCRI) in Avatar **Crisis Episodes**	**Housing** LOCRI Questions 5. Housing scale **Employment** LOCRI Questions Currently employed: yes/no **Crisis Episodes**

Arrests down	Avatar Report - Crisis Services Client Tracker in Avatar **Psychiatric Hospitalizations** Inventory (LOCRI) in Avatar **Arrests** Adult Level of Care and Recovery Inventory (LOCRI) in Avatar	Time between crisis events **Psychiatric Hospitalizations** Number of Hospitalizations per client **Arrests** LOCRI Questions Number of arrests. 6. Incarceration scale (last 6 months)